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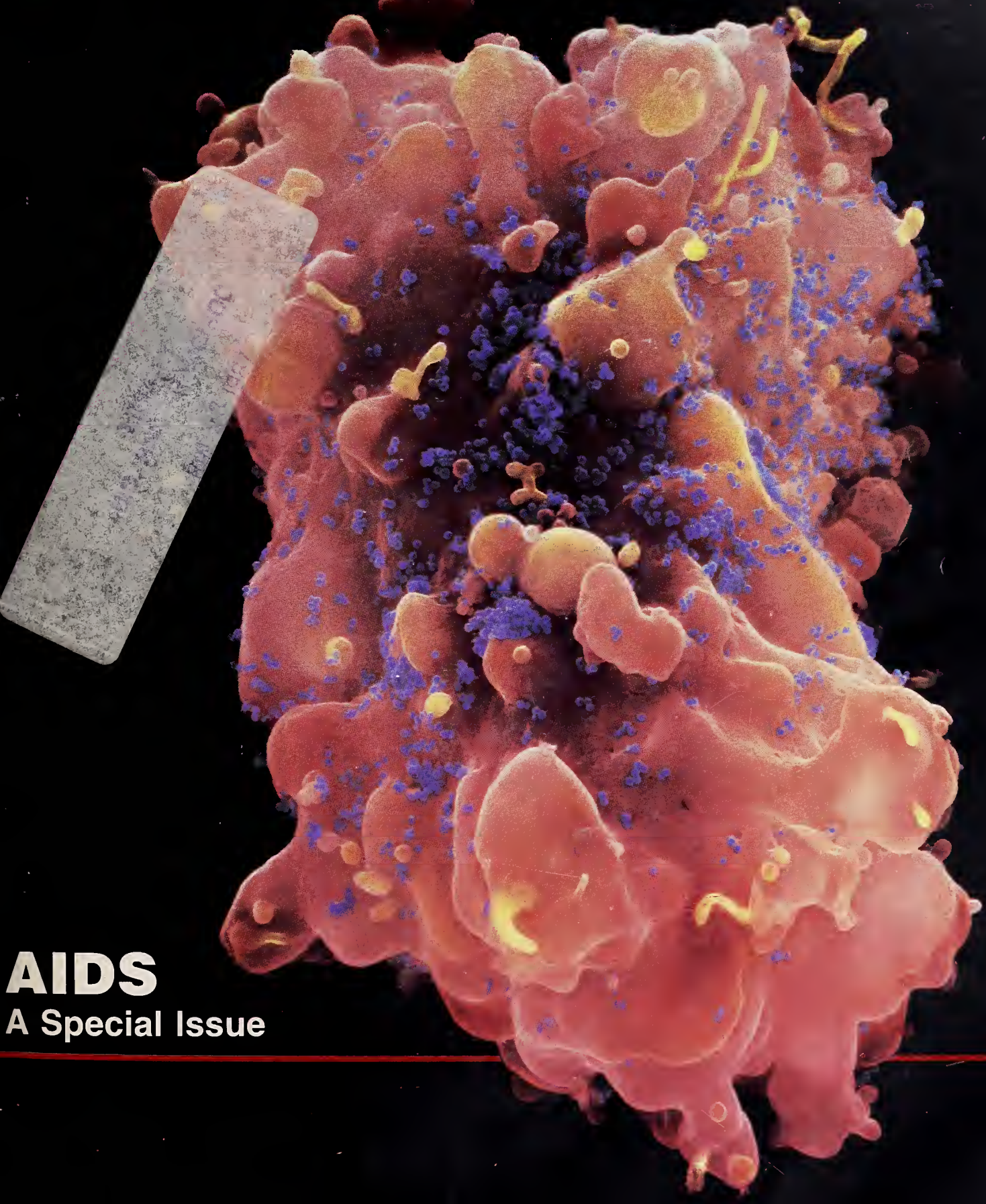
JANUARY 1987

# JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA



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# CONTENTS

VOLUME 76, NUMBER 1

## FEATURES

AIDS: THE GEORGIA PERSPECTIVE 16
By Pierre B. Bland, D.V.M., Joseph A. Wilber, M.D., R. Keith Sikes, D.V.M., and Frank Rumph, M.D.

PSYCHOLOGIC ISSUES RELATED TO AIDS 28
By Robert L. Blaney, Ph.D., and Gary E. Piccola, Ph.D.

MEETING THE MENTAL HEALTH CHALLENGE OF AIDS AND RELATED DISORDERS 33
By Sarah W. Holmes, M.A., and Jesse Peel, M.D.

AIDS IN *MY* PRACTICE? 36
By Bridgette B. Nahmias, M.D.

THE GEORGIA TASK FORCE ON AIDS 40
By W. Douglas Skelton, M.D.

SURGEON GENERAL'S REPORT ON ACQUIRED IMMUNE DEFICIENCY SYNDROME 48

INTERNATIONAL CONFERENCE ON AIDS IN CHILDREN, ADOLESCENTS, AND HETEROSEXUAL ADULTS 56

YOU AND MALPRACTICE STRESS: IV. THE OFFICE STAFF'S PERSPECTIVE 61
By Rachel Blum, J.D.

TORT REFORM 13

## EDITORIAL

A PLAGUE AMONGST US? 14
By Charles R. Underwood, M.D.

## LEGAL

LEGAL ISSUES INVOLVING AIDS 64
By James H. Coil, III

## CANCER

UNPROVEN METHODS OF TREATMENT 69
By Thomas W. Phillips, M.D.

## HEART

CARDIAC TRANSPLANTATION IN GEORGIA 70
By G. Lionel Zumbro, M.D., Gail Harville, R.N., Ronald F. Galloway, M.D., and William R. Kitchens, M.D.

## DEPARTMENTS

PRESIDENT'S PAGE 7
LETTERS TO THE EDITOR 8
CALENDAR 9
EDITOR'S CORNER 11
ASSOCIATION NEWS 74
INDEX TO ADS/MANUSCRIPT INFORMATION 78

## COVER

AIDS — the hotly debated disease of the 1980s — is the focus of this special issue of the *Journal*. Many subjects are discussed, and many of your questions about this intriguing and tragic disease are answered.

The cover features an electron micrograph of a human T-cell lymphocyte being attacked by AIDS viruses (blue spots). Photo by Lennart Nilsson, of Stockholm, Sweden; copyright Boehringer Ingelheim International GmbH.

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*John D. Watson, Jr., M.D.*

# *Circle The Wagons*

A NON-MEDICAL colleague of mine recently made a statement about physicians after observing one of our more heated societal meetings. He said, "When engineers or accountants are attacked as a group, they circle the wagons and shoot out. When doctors are attacked as a group, they circle the wagons and shoot in." I am afraid that on many occasions he is very correct.

It is certainly appropriate and necessary for us to have thorough debate on significant issues. And similar to members of a family, we will not always totally agree on every issue. However, we in the family can criticize and agree to disagree with each other, but you better not let anyone outside the family jump on us or attack the family.

I wish the family of medicine felt this way more completely. When we collectively agree to do something that the majority of the "family" concurs is the right path to take, should we not support the decision fully? Is it proper for us an intelligent professionals to sulk, balk, refuse to participate, refuse to support, and openly try to subvert the will of the majority? Is this the type of loyalty you expect from members of your family?

Friends, it is time to circle the wagons. We have potent adversaries out there. We can succeed if we act together, as one dedicated family, each of us promoting and defending that family, each one of us, not just a few. You and I both know what you and I have to do. Now, not next week, next month, next year, but now. Never let it be said that we could have won if only everyone had helped — if only we had applied our massive strength and influence — if only we had personally made those contacts. Think about it!

Sincerely,

John D. Watson Jr. M.D.

## *Smokeless Tobacco*

Dear Editor:

I read with interest the article in the *Journal* (May, 1986, pp. 278-279) by Dr. John West entitled, "Smokeless Tobacco: A Problem for Health Professionals and Educators."

While I certainly share Dr. West's concern both in regards to the morbidity and mortality experienced with cancer of the mouth and the public health responsibility which rests upon us in regard to identification of significant risk factors, certain elements of his article are disturbing.

The statement that, "Smokeless tobacco is the major cause of cancers of the oral cavity and pharynx in the United States . . ." is completely unsupported by *any* epidemiological evidence. Departures from accuracy of this magnitude to not reflect favorably on our efforts to preserve scientific credibility. In the period 1970-1979, Georgia and Massachusetts were roughly comparable in population but the incident cases of oral cancer in Massachusetts exceeded that of Georgia by some 70%; usage of smokeless tobacco in Massachusetts can be considered to a small fraction of Georgia's.

Additionally, reliance on incidence of any noncommunicable disease over a short time span, and in a small restricted location, for purposes of generalization is not fruitful. The author cites an unusually high oral cancer rate in LaGrange, Georgia, over a 4-year span. Information from the National Cancer Institute shows that there are tremendous inter-*county* fluctuations in oral cancer mortality rate with Georgia, and within any one country, over defined decades. For example, the white male oral cancer mortality rate on Gordon and Jeff Davis counties for 1950-1959 was 10.4/100,000 and 11.1/100,000 respectively (U.S. average = 4.8/100,000). An attempt to correlate this with smokeless tobacco or any other oral habit or dietary custom would be unconvincing when in the 1960-1969 10-year span, the rate dropped to 2.4 and 3.0, respectively. Similarly, Clayton county experienced fluctuations over a three-decade span of 2.0, 8.8, and 3.7/100,000.

We must decide, as health professionals, if the public interest is best served by adherence to careful scientific methodology in reporting or passionate but anecdotal opinion.

*Very truly yours,*
*John Richardson, D.D.S.*
*Professor and Chairman*
*Department of Oral Pathology*
*Boston University*

## *AIDS Controversy*

Dear Editor:

I want to thank Dr. J. Nicholas Gordon for his letter [to the editor] published by the Medical Society about the failure of the CDC to act responsibly to control the AIDS epidemic [JMAG, Oct. 1986, p. 584].

I too think the CDC has failed in its mandate. I wrote several letters to Senators Mattingly and Nunn; and in response, I have received letters from the CDC which blamed the shortage of money, the lack of jurisdiction, and civil right laws for their failure to use the normal epidemiological techniques to contain the AIDS epidemic. This is the same outfit that spent millions to recall cheese, tylenol, and sanitary tampons, which were minor national health threats when compared to AIDS.

I would also question why the CDC ever raised the civil rights issue for a contagious and epidemic disease when no other contagious disease, venereal or otherwise, has ever had this status. The threat of lawsuits from issues of confidentiality hamper infection control measures, makes curbside consultation, diagnosis and treatment difficult, and throttles scientific discourse. We whisper in the hall whenever we have to deal with an AIDS patient.

*The Wall Street Journal* and *The Atlanta Constitution* are questioning the very definition of AIDS used by CDC, since it ignores many of those w die infected with HTLV-LAV. Son thing is very wrong when the latest formation comes from a financial ne paper rather than the Government.

Ignoring an epidemic will not mak go away. We have many hundreds AIDs patients in Atlanta and will h thousands in a year or two, and we totally unprepared. No nursing home hospice in all of Georgia will ad someone with AIDS.

The CDC had an enviable reputati prior to the AIDS epidemic, but n appears to have an agenda other th disease control. As President Johns discovered, we are known for our f ures when they are big enough.

*Sincerely,*
*Olav Henry Alvig, M.D.*
*Cumming*

## QUOTES

*There are no circumstances, howeve unfortunate, that clever people do n extract some advantage from.*
La Rochefoucauld

*Results are gained by exploiting opportunities, not by solving proble*
Peter Drucker

*Do something for somebody every d for which you do not get paid.*
Albert Schweitzer

*Although the world is very full of suffering, it is also full of overcomin it.*
Helen Keller

*Happiness adds and multiplies as w divide it with others.*
A. Nielen

*The way to love anything is to realiz it might be lost.*
G. K. Chesterton

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— *Atlanta:* **Cancer Prevention Control for Black Americans.** tegory 1 credit. Contact Janet nfiglio, Ga. Div., American ncer Society, 1422 W. Peachtree , Atlanta 30309. PH:404/892-26.

21 — *Atlanta:* **International nference on AIDS in Children, olescents and Heterosexual ults.** Sponsored by International erdisciplinary AIDS Foundation. ntact Emory Pediatrics, 69 Butler SE, Atlanta 30303. PH:404/ 9-4997.

21 — *Augusta:* **Flexible eroptic Sigmoidoscopy.** tegory 1 credit. Contact Div. of nt. Ed., MCG, Augusta 30912. :404/828-3967.

22 — *Atlanta:* **Georgia Society Anesthesiologists Annual eting.** Category 1 credit. Contact ın B. Neeld, Jr., MD, 1000 ınson Ferry Rd., NE, Atlanta 342. PH:404/255-7512 or :hael R. Murphy, MD, 1365 ton Rd., Atlanta 30322. PH:404/ 1-0111.

23-27 — *Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

25-March 1 — *Cozumel, Mexico:* **Scottish Rite Children's Hospital 9th Annual Pediatric Postgraduate Course.** Category 1 credit. Contact Darlene Baugus, RN, Ed. Dept., 1001 Johnson Ferry Rd., Atlanta 30363. PH:404/252-9377.

26-March 1 — *Sea Island:* **The Southeastern Angiographic Society.** Category 1 credit. Contact Dixie H. Harris, Exec. Secy., Southeastern Angiographic Society, P. O. Box 308, Hickory, NC 28603. PH:704/322-2871.

26-27 — *Atlanta:* **Optimizing Outcome For Survivors of Traumatic Head Injury.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

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## MARCH

2-7 — *Augusta:* **22nd Annual Family Practice Symposium.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

5-7 — *Atlanta:* **The 2nd International Interdisciplinary Conference on Hypertension in Blacks.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

9-13 — *Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

16-18 — *Atlanta:* **Southeastern Surgical Congress.** Category 1 credit. Contact Roger Sherman, MD, Dir., SSG, 69 Butler St., Ste. 314, Atlanta 30303. PH:404/221-0570.

18-20 — *Hilton Head Island, SC:* **Eighth Annual Symposium on Clinical Management of Diabetes and Endocrine Disorders.** Category 1 and AAFP prescribed credit. Contact Edwin D. Bransome, Jr., MD, MCG, Augusta 30912. PH:404/828-3445.

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*"We seek simple, oughtful, and eaningful expressions f what is going on in e minds of those of us ho practice medicine in is state."*

"EVERY GREAT INSTITUTION," so said Ralph Waldo Emerson, "is but the shadow of a great individual." Not so the *Journal of the Medical Association of Georgia*. It is rather the shadow of several great and perhaps not so great men and women. It will live or die, do well or ill, directly in proportion to the interest and the input of each of you. I shall do my best to keep the machinery oiled, attend to daily maintenance, "make rounds" at proper intervals if you will, but you must put the gas in the tank to make it go.

The scientific articles must come from you, from large towns and small towns, from academics and just plain practicing physicians, from practiced writers and from those not so polished, from those accustomed to saying much and saying it often, and from those unaccustomed to divulging important information. You must generate that material and send it to us. We will look it over, ask peer experts to review it and pass judgment on whether or not it deserves publication. They will do that with the prerogative of making suggestions both as to content and as to grammar. It will all be done with no intent to offend but rather with the clear purpose of generating useful and printable material for this *Journal*.

And then we need your thoughts on other subjects beyond the science of life. We need to know what you think of health care matters generally. Some of us are more competent in financial areas than are others. We need to know your thoughts and your analyses of the trends in financing health care. What indeed happened to the patient/physician relationship when we changed from a chicken and a bag of potatoes for an appendectomy to C.P.T. code 44950? Are you comfortable being a "provider" rather than a "physician"? Would you rather go back to the days when Hugh Wood, Dean of the Emory University School of Medicine some several years ago, told us, "I like to see a patient have a doctor, not a doctor have a patient"? We need to have that kind of thinking from you and perhaps not as highly sophisticated as you might fear. We seek simple, thoughtful, and meaningful expressions of what is going on in the minds of those of us who practice medicine in this state.

And, then, we need your suggestions and your criticisms. I have lived part of my life in a world befriended by those who chose to comment favorably upon my actions, parents and grandparents and gentle friends. I have lived the more useful and stable — albeit the more restless — portion of my life more securely befriended by those certain enough of our relationship to say frankly just how things were going. You need to tell this *Journal* and this Editor of your reactions to what you see printed here. We are human and as such we are fallible. We need the broad brush stroke of the opinion of each of you to make the picture meaningful, if not beautiful.

And what shall this *Journal* become should all this come to pass? That to me is the magic of it all. I have no earthly idea. I only know that the capacity for good or poor performance is within us all. It simply awaits awakening. I only know that, "Angels fly well because they take themselves so lightly."

*Charles R. Underwood, M.D.*
*Interim Editor*

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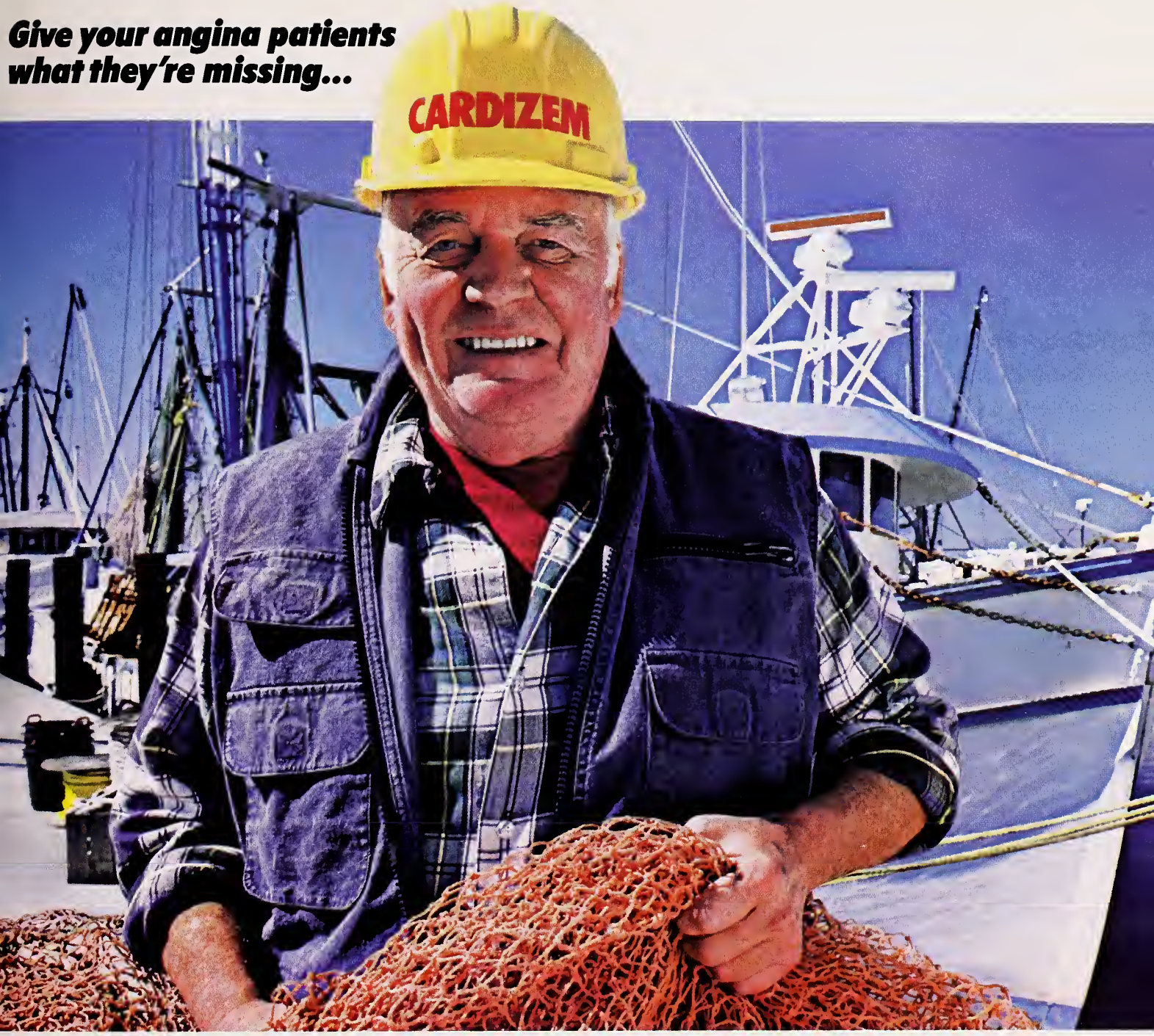


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# CARDIZEM® FEW SIDE EFFECTS IN ANTIANGINAL THERAPY

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60 mg tid or qid

**Brief Summary**
Professional Use Information

**CARDIZEM®**
(diltiazem HCl) 30 mg and 60 mg Tablets

**CONTRAINDICATIONS**
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

**WARNINGS**

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

**PRECAUTIONS**
**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.
**Drug Interaction.** Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)
Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.
**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.
**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.
There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.
**Nursing Mothers.** Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.
**Pediatric Use.** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS**
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.
In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.
The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

| | |
|---|---|
| Cardiovascular: | Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope. |
| Nervous System: | Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor. |
| Gastrointestinal: | Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase. |
| Dermatologic: | Petechiae, pruritus, photosensitivity, urticaria. |
| Other: | Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties. |

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. *Issued 7/86*
See complete Professional Use Information before prescribing.

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# Tort Reform 1987

The reforms that the Medical Association of Georgia and the Georgia Liability Crisis Coalition are seeking are listed below. It is similar to legislation that has already been enacted in California, New York, Illinois, Florida, and other states. Try to familiarize yourself with these proposed changes so that you will be able to convey your support to elected officials intelligently and informatively. If you have any questions, please call the MAG Office of Legislative Affairs (404) 876-7535.

**1. Disclosure of Collateral Sources** of payment to plaintiff will allow juries to be informed of additional payments a plaintiff may have received for the same injury. For example, a plaintiff may have received compensation for the same injury from an insurer, an employer and/or a government source. Requiring disclosure of collateral sources of payment will eliminate double payment for the same injury. Thus, juries may make educated decisions as to the economic ramifications of a case, reasonable injury values and eliminate duplicate payments.

**2. Cap on Non-Economic Losses and Punitive Damages** provides for a ceiling of $250,000 on intangible losses. Because considerations, such as pain and suffering, loss of consortium and punitive damages are impossible to ascertain, a cap on these non-economic losses assures "reasonable" compensation. This reform measure in no way will affect compensation for lost wages or medical expenses. A 1982 Rand Institute for Civil Justice report found that states with caps had an average drop of 19 percent in the severity of awards within two years of enactment.

**3. Judicial Authority to Modify Awards,** subject to the agreement of all parties involved, will allow judges to increase or decrease awards appearing inadequate or excessive. Currently in Georgia, when a verdict is grossly out of line, the only existing recourse is further costly litigation. Allowing experienced trial judges to lend expertise to the formation of a reasonable and equitable award, as is being proposed, will minimize legal expenses, taxpayers' cost for the court system, insurance rates and costs to consumers.

**4. Structured Settlements** will require that awards and settlements more than $100,000 be structured into periodic payments, with appropriate consideration for immediate economic need. This reform measure guarantees reasonable reimbursement for current expenses, while assuring availability of funds to meet future needs. It has been determined that the majority of large awards are completely spent within five years, although economic need for assistance for an injury may continue. Structured settlements guarantee a reliable stream of income to meet future needs of the injured party, while avoiding "windfalls" to heirs.

**5. Joint and Several Liability Reform** in personal injury cases would ensure that defendants be liable only for that portion of the total damages which can be attributed to each. Currently, in cases where there may be multiple defendants, a claimant can recover the full amount of any judgment from any one of the co-defendants, usually the one in the best financial condition. Reform of joint and several liability would eliminate this inequity and re-establish balance to the system of recovery of damages.

**6. Statute of Limitations for Minors** be changed to age 6 plus two years, and that thereafter, the same two-year statute that applies to adults be applied to minors. The statute as it applies to foreign objects would remain the same: 1 year from the date of discovery of the object. By imposing a reasonable time period within which a special liability suit may be initiated, the open-endedness or "long-tail" is reduced to a more manageable form, while preserving the claimant's rights to seek compensation for injuries. It will commit insurance companies to use data that is more realistic, to set up rates that are more actuarially predictable so that savings can be passed on to the consumer. Also, by reducing the long-tailed exposure, there will be a minimalization of the inevitable disadvantage and unfairness in trying to reconstruct an event that occurred so many years prior to the suit. It is generally acceptable that the specter of a lawsuit should not continue for an indefinite time. This burden is unreasonable, inequitable, and unjustifiable.

**7. Attorney Contingency-Fee Regulation** has been adopted in 23 states and is used nationwide in federal government cases. Similar guidelines for attorney fees are being proposed for Georgia. Such reform will provide a sliding scale for attorney contingency fees, ensuring that the bulk of an award goes to the injured party, while maintaining fair and reasonable compensation for attorneys. This measure calls for claimant's attorneys to receive 33% of the first $150,000; 25% of the next $250,000 and 15% of the balance. A five-year study conducted by the American Bar Association noted that, in general, when lawyers work on a contingency fee basis, "lawyers are benefiting," not clients.

**8. Mandatory Review by any Licensing Arm of the State.** This measure calls for review and disciplinary action by any state licensing board when an individual certified by that board is involved in a substantiated liability lawsuit with a settlement or award of more than $100,000. The Georgia Liability Crisis Coalition believes that if a liability award is due to genuine professional incompetence, the matter should not end with the payment of an award. The individual in question should be reviewed and sanctioned accordingly by the appropriate state licensure board.

WARNING: Excessive Liability Costs May Be Hazardous To Your Health.

# A Plague Amongst Us?

*"The gods are just, and of*
*our pleasant vices*
*Make instruments to plague us."*
*Wm. Shakespeare*
King Lear

As I HAVE THOUGHT about AIDS, talked with my patients about the disease, surveyed the medical literature, and listened to fellow physicians, it appears that we are dealing with an epidemic — a plague if you will — in a sociologic and psychologic sense, if not indeed in a biologic one. I questioned one of my fellow physicians, a specialist in infectious diseases, as to whether or not AIDS represented something akin to the Plague, the Black Death. He said no. Rather, he said, it was more akin to such diseases as syphilis.

***"It seemed to me that we were dealing with something similar to these catastrophic infectious disease problems that had decimated the human race on occasion throughout recorded history."***

I wondered about that, for it seemed to me that we were dealing with something similar to these catastrophic infectious disease problems that had decimated the human race on occasion throughout recorded history. My patients were asking concerning each operation, be it the most minor or the most serious, whether or not transfusions would be given. Talk was rampant as to whether or not casual contact, as with sweat or tears, could spread the disease. Scrub nurses were running from the operating table in panic when blood accidentally touched any part of their exposed body. The various media were saturated with information to the general public as to the nature of the disease and the protections one might take against it. Children were being banned from public schools and isolated for their studies at home. The sociologic and psychologic reaction among the lay and professional public seemed to be akin to that one might read about concerning the great pandemics of the past.

### Diseases in History

The disease of leprosy has been known since ancient times, having been mentioned in the Brugsch Papyrus (2400 B.C.) where one found the suggestion that it had been carried from Egypt by the Israelites into the Promised Land.[1] It became pandemic between the 11th and 13th Centuries, at which time isolation of those afflicted resulted in the establishment of some 19,000 Leprosaria throughout the Christian world. One can read of these lepers roaming the countryside, wandering from village to village, wearing by order of authorities an identifying black cloak with two white patches on the breast while carrying a rattle to give warning to anyone approaching them.

There followed the Black Death, said to have first appeared around 1134 in China and spreading along trade routes throughout Europe. It h been estimated that Europe lost som twenty-five million people to the disease. Guy de Chauliac, mentione by Major in his *History of Medicine* left clear descriptions of the Plague: "It was believed the Jews had poisoned the people and they killed them (the Jews) . . . Or it was the poor cripples, and they chased them away, and others thought it was the nobles, and so they were afraid to g among the people." The persecutior of the Jews became rampant, as in Basel and Freiburg; "all the known Jews were seized, herded into a wooden building, and burned to dea while in Strassburg, 2,000 Jews wer hanged on a scaffold erected on the Jewish burial grounds."[1]

There have been many other lesse or greater epidemics. As recently as the medical lifetime of many of us s practicing, one can recall tuberculos and the fear that gathering in public places, breathing dried spittle upon t street, could lead to a disease which we found necessary to isolate in sanitaria. As recently as the second quarter of the 20th Century, one can easily recall such institutions as Grac Memorial Hospital in Atlanta where three-story building housed and isolated those afflicted with poliomyelitis — a disease where in warm summer months parents feared for their children possibly exposed ir public swimming areas or crowded public gatherings. Many of us can st recall the deadly effects of diphtheri

# EDITORIAL

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***‘Perhaps AIDS is not in to the great ndemics of the past . . . t) there seems a nilarity in the mystery of thing.’’***

m a high ecclesiastical position has
e the admonition that it was the
aking of God's vengeance upon
sinful people (homosexuality). Yet
caution too was not of recent
tage, for we had been told by
ton Mather in 1692, ‘‘tis the
troyer or the Devil that scatters
gues about the world. . . . (He)
regnates the air with such
lignant salts as, meeting with the
of our microcosm, shall
nediately cast us into that
nentation and putrefaction which
utterly dissolve all the vital ties
hin us.’’[2]
erhaps the most recent description
situation similar to the one which
find ourselves in was given by
ert Camus who, in 1957, won the
bel Prize for literature primarily for
ook he wrote called *The Plague*.
hough Camus wrote more to describe the fragility of the human condition, a symbolic novel if you will, he nonetheless painted our clearest modern picture of the emotional reaction to a threatened pandemic:

*‘‘It is noteworthy — this may or may not have been due to mere coincidence — that this Sunday of the sermon marked the beginning of something like a widespread panic in the town, and it took so deep a hold as to lead one to suspect that only now had the true nature of their situation dawned on our townspeople. . . . Since this first onslaught of the heat synchronized with a startling increase in the number of victims — there were now nearly 700 deaths a week — a mood of profound discouragement settled on the town. In the suburbs, little was left of the wonted animation between the long flat streets and the terraced houses; ordinarily people living in these districts used to spend the best part of their day on their doorsteps, but now every door was shut, nobody was to be seen, even the venetian blinds stayed down, and there was no knowing if it was the heat or the plague that they were trying to shut out. In some houses groans could be heard. At first, when that happened, people often gathered outside and listened, prompted by curiosity or compassion. But under the prolonged strain it seemed that hearts had toughened; people lived beside those groans or walked past them as though they had become the normal speech of men.’’*[3]

Perhaps my friend is correct. Perhaps AIDS is not akin to the great pandemics of the past. I only know that as one reads of those great infectious disease ‘‘natural disasters’’ of the past, there seems a similarity in the mystery of the thing. A sameness in the reaction of people to the unpredictability of what is going on. A near panic as to whom will be the next afflicted. The hope lies clearly in the rapidity with which our present day technology achieves answers concerning etiology, contagiousness and, with some luck, control in the not too distant future. You will find elsewhere in this special issue of the *Journal* articles dealing with several aspects of this disease. Read them thoughtfully, for there are emerging some answers to those many questions we have been faced with over the past year or so. Read them with the knowledge that with understanding comes wisdom and control of panic.

***‘‘Read them (the articles in this special issue of the* Journal*) with the knowledge that with understanding comes wisdom and control of panic.’’***


**References**

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*Charles R. Underwood, M.D.*
*Interim Editor*

# AIDS: THE GEORGIA PERSPECTIVE

PIERRE B. BLAND, D.V.M., JOSEPH A. WILBER, M.D.,
R. KEITH SIKES, D.V.M., M.P.H., FRANK RUMPH, M.D.

In June, 1981, the Acquired Immunodeficiency Syndrome (AIDS) was first identified in the United States when the Centers for Disease Control (CDC) noted increased requests for a new drug used in the treatment of *Pneumocystis carinii* pneumonia (PCP), a condition previously seen only in immune suppressed individuals. Upon investigation, it was found that these patients with PCP were male homosexuals who had evidence of severely depressed cellular immunity of unknown cause. Another unusual feature was that many of the patients also had Kaposi's sarcoma, a rare cancer usually seen only in elderly men. Subsequently, it was found that since 1978, homosexual men in major cities throughout the country had been dying of this mysterious new disease.

In 1983, American and French research teams independently discovered that AIDS was caused by a virus. Gallo and his coworkers at the National Cancer Institute named the virus, Human T-Lymphotropic Virus Type III (HTLV-III), while Montagnier of the Pasteur Institute called the virus Lymphadenopathy-Associated Virus (LAV). Recently, HTLV-III/LAV has been renamed the Human Immunodeficiency virus (HIV).[1] HIV is a member of the family of viruses called retroviruses (See Figure 1).

HIV is known to be transmitted by blood, blood products, and semen. It has been found in other body fluids, but transmission is unproven. When the virus enters the blood stream, it invades the T-4 helper lymphocytes, the mediator cell of the immune system. Once inside the lymphocyte, the virus sheds its protective protein coat, exposing its core, which contains ribonucleic acid (RNA). The virus uses reverse transcriptase to translate the invading RNA into deoxyribonucleic acid (DNA), which is inserted into the chromosomes of the host cell in preparation for virus reproduction. Once gene insertion occurs, it is likely that the individual is infected for life.

Virus reproduction may lie dormant for weeks, months or years depending upon unknown factors. The virus multiplies by budding from the surface of the T-4 cell (See Figures 2 and 3) which is eventually destroyed in the process. As the disease progresses, the infected cell becomes a "factory" for the production of HIV. More and more T-4 cells are destroyed, the immune system of the infected individual fails, and he or she becomes vulnerable to a host of opportunistic infections, cancers, and neurologic disorders.[2]

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## Epidemiology

In July, 1981, the first cases of AIDS were reported in Georgia. There were three cases: a homosexual male with *Pneumoncystis carinii* pneumonia, another homosexual male and a heterosexual Haitian male both with

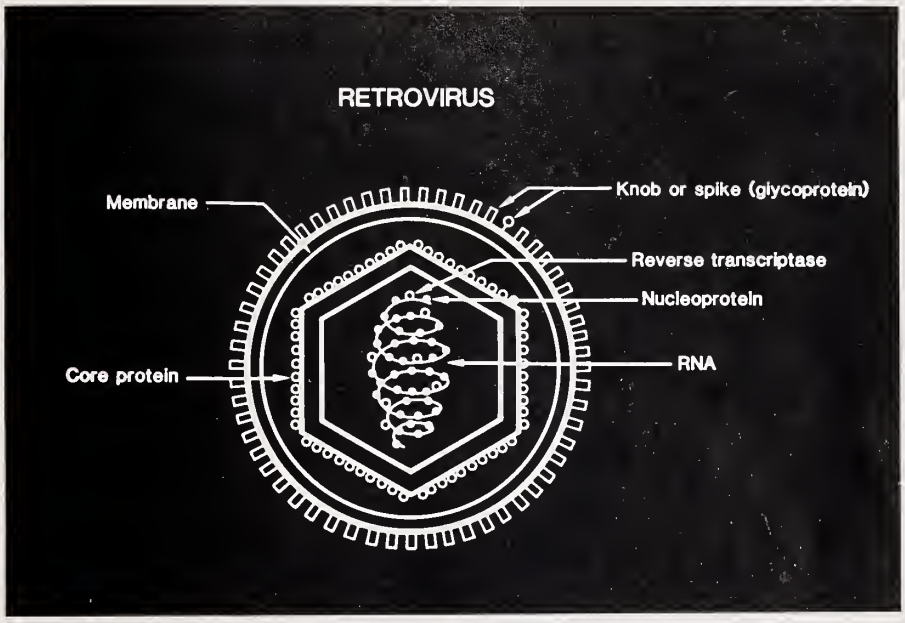


*Figure 1 — The major components of a retrovirus. (Illustration courtesy of U.S. Centers for Disease Control, Atlanta, Georgia, and Erskine Palmer, Ph.D.)*

Kaposi's sarcoma. From an initial three cases, the number increased to six in 1982, and then to 25 in 1983. As of December 1, 1986, there have been 571 reported cases of AIDS in Georgia, with 321 deaths, resulting in a 5-year fatality rate of 56% (Figure 4). Of the reported cases, 426 (75%) have been homosexual or bisexual men, 39 (7%) intravenous drug abusers, 39 (7%) homosexual or bisexual intravenous drug abusers, and 11 (2%) were heterosexual contacts of either verified cases or high risk individuals (2 men and 9 women). The remaining 9% include hemophiliacs (5), blood transfusion recipients (19), pediatric cases (7), and 23 cases with no identifiable risk factor. Whereas cases previously were doubling in Georgia every 9 months, currently, it is estimated that cases are doubling every 11 to 12 months. According to the CDC, Georgia alternates between 9th and 10th with Washington, DC in the number of nationally-reported AIDS cases. If the current rate of cases and fatalities continue, by 1990 there will be an estimated 6100 cases in the state with 3800 deaths.

***"The virus uses reverse transcriptase to translate the invading RNA into DNA, which is inserted into the chromosomes of the host cell in preparation for virus reproduction."***

A comparison of the transmission categories in Georgia with those of the United States is shown in Table 1. As can be seen in the adult cases, Georgia has a lower percentage of heterosexual drug abusers, and in the pediatric group, there are no reported hemophilia cases and more transfusion-related cases.

In January, 1984, the Georgia Board of Human Resources designated AIDS as a reportable disease in Georgia. An active surveillance program was established by the Department of Human Resources (DHR), Office of Epidemiology, in October of the same year. For reporting purposes, the state is divided into four regions: North, Metro Atlanta, Middle, and South Georgia. To insure confidentiality, cases are not publically identified by county, city, or town. As of December 1, 1986, 40 (7%) of the cases have been reported from North Georgia, 441 (77%) from Metro Atlanta, 45 (8%) from Middle Georgia, and 45 (8%) from South Georgia. One hundred forty-six (26%) of the cases are in the age group 20-29, and 367 (64%) in the 30-49 age range. The racial proportion of cases is in keeping with the state's adult population distribution, 405 (71%) of the cases being white, 156 (27%) black, and 10 (2%) Hispanic.

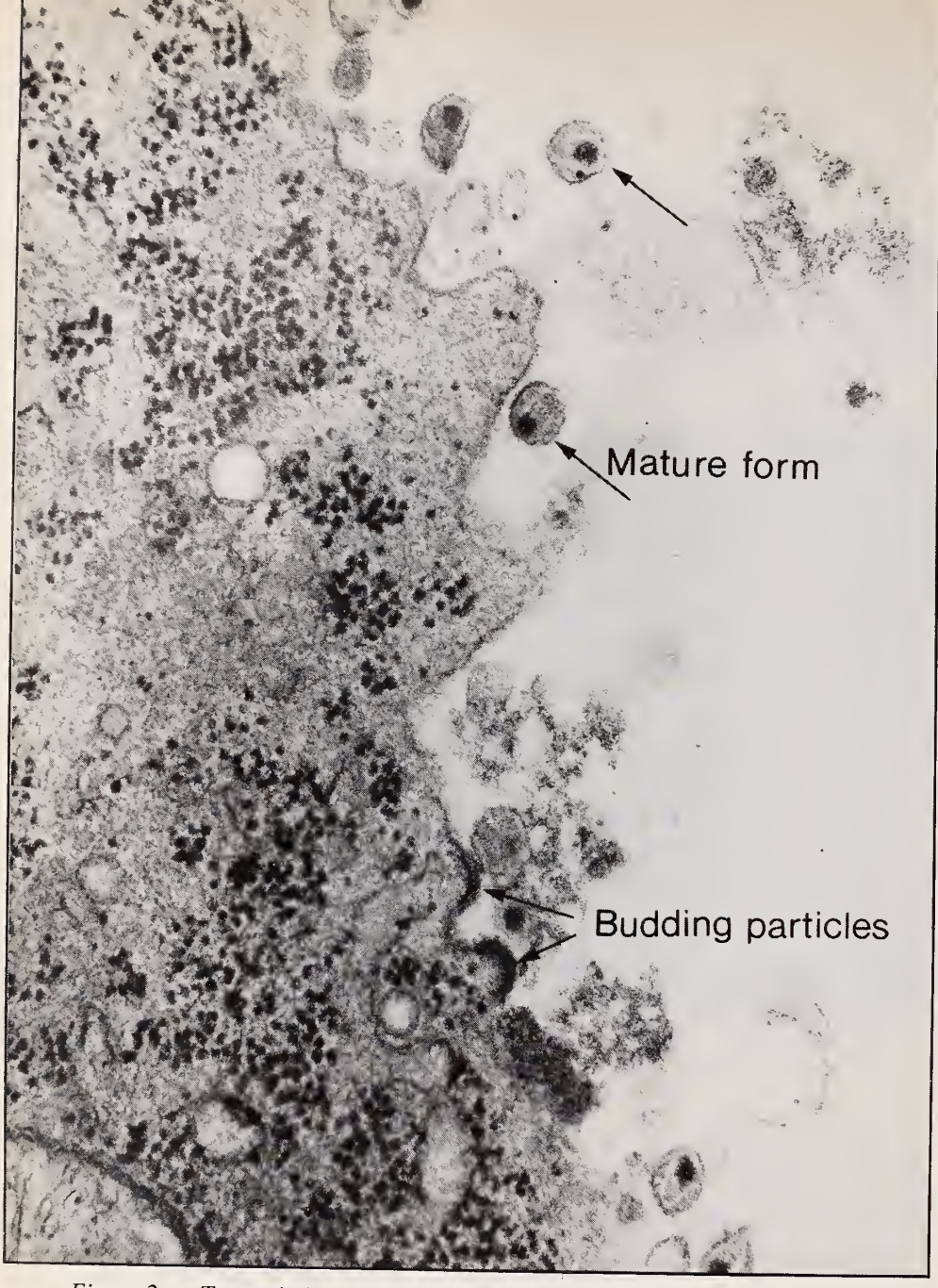


*Figure 2 — Transmission electron micrograph of HTLV-III particles budding from the plasma membrane of an infected cell. Magnification of virus particles ranges in size from 90-120 mm. (Illustration courtesy of U.S. Centers for Disease Control, Atlanta, Georgia, and Erskine Palmer, Ph.D.)*

### Transmission

The AIDS virus has been found to be transmitted by intimate sexual contact, shared contaminated needles, the injection of infected blood or blood products, and across the placenta from mother to fetus. Casual contact with an infected person, whether symptomatic or asymptomatic, has not been found to transmit HIV infection. This includes living in the same household, sharing eating utensils, clothing, or toilets. There is also no evidence that insect vectors, such as lice and mosquitoes, or vaccines are implicated in the transmission of HIV infection.[3, 4, 5]

### AIDS Definition

To qualify as a reportable case of AIDS in Georgia, all cases must fit the CDC surveillance definition, which is as follows:

*"For the limited purposes of national reporting of some of the severe late manifestations of infection with HTLV-III/LAV (HIV) in the United States, CDC defines a case of "acquired immunodeficiency syndrome" (AIDS) as an illness characterized by:*

*I. One or more opportunistic diseases diagnosed by methods considered reliable (histology, cytology, endoscopic examination, or culture) and the disease has to be at least moderately indicative of cellular immunodeficiency (Table 2).*

*II. Absence of all known underlying causes of cellular immunodeficiency other than HTLV-III (HIV) infection and absence of all other causes of reduced resistance reported to be associated with at least one of those opportunistic diseases (Table 3).*

*Despite having the above, patients are excluded as AIDS cases if they have negative results on testing for serum antibody to HTLV-III (HIV), do not have a positive culture for HTLV-III (HIV), and have both a normal or high number of T-helper (OKT4 or LEU2) lymphocytes. In the absence of test results, patients satisfying all other criteria in this definition are included as cases."*[6]

The CDC has recently published a new classification system for HIV infection.[7] Group IV, subgroups C, D, E correspond to the official CDC surveillance definition (Table 4).

### AIDS-Related Complex

There is no national definition of AIDS-Related Complex (ARC). However, there is general agreement that ARC patients are a group who test positive for HIV antibody and who exhibit various degrees of illnesses, usually including generalized lymphadenopathy, unexplained weight loss, persistent low grade fever, and/or diarrhea. They also may have atypical tuberculosis, oral thrush, hairy leukoplakia, herpes zoster, and central or peripheral neuropathy. Dementia due to encephalitis or cerebral lymphoma also is not rare. Some of these ARC cases may die before they meet the CDC definition. Group III and IV, subgroups A, B, of the CDC classification correspond to the usual definition of ARC (Table 4).

The diagnosis and treatment of the opportunistic infections and complications of ARC and AIDS are complex, difficult,and involve many disciplines and specialties. As the epidemic has spread in Georgia, most

communities with large general hospitals have developed and identified physicians knowledgeable and experienced in this disease. If the physician is seeing his or her first suspected case of ARC or AIDS, expert consultation is advised.

### Reporting

Georgia law requires that all patients meeting the CDC definition be reported to the Georgia AIDS Project, Division of Public Health, Department of Human Resources (DHR). If the patient is hospitalized, the case should be reported to the hospital infection control nurse. Non-hospitalized cases may be reported directly to the Georgia AIDS Project by calling (404) 894-6526. All cases are kept confidential and reported only in statistical form. Individuals having only positive HIV serology and patients who display signs and symptoms that the physician feels are indicative of ARC are not required to be reported. Compilations of reported data and current information on AIDS are presented in "AIDS Update," a monthly publication produced by the Georgia AIDS Project (copies are available upon request).

*Figure 3 — Scanning electron micrograph of a population of lymphocytes infected with HTLV-III. Note the minute viruses on the surfaces of the cells. (Illustration courtesy of the U.S. Centers for Disease Control, Atlanta, Georgia, and Erskine Palmer, Ph.D.)*

### Testing and Counseling

In March of 1985, the U.S. Food and Drug Adminstration licensed several enzyme-linked immunoassey (ELISA) tests to detect antibodies to HIV. Since the tests were designed for screening the nation's blood supply, they are highly sensitive; however, the specificity varies according to the manufacturer. Because of this characteristic, positive ELISA results should be checked by a supplemental procedure such as the Western Blot test. Because HIV antibody test results have an unknown prognostic significance and the virus is not transmitted by casual contact, the test should not be used for generalized screening, as a precondition for employment, or admission to schools. Testing should be performed only with the consent of the individual and only when it is of benefit to the patient or to public health.[8]

Due to the serious potential for social and psychologic harm to individuals resulting from positive HIV an-

**TABLE I — Acquired Immunodeficiency Syndrome (AIDS)**
**Georgia and United States* — December 1, 1986**

| | *Males* | | *Females* | | *Total* | |
|---|---|---|---|---|---|---|
| *Transmission Categories* | *GA Number (%)* | *US Number (%)* | *GA Number (%)* | *US Number (%)* | *GA Number (%)* | *US Number (%)* |
| **ADULTS/ADOLESCENTS** | | | | | | |
| **Homosexual/Bisexual Male** | 426 (70) | 18,229 (70) | | | 426 (76) | 18,229 (65) |
| **Intravenous (IV) Drug Abuser** | 34 (15) | 3,791 (15) | 5 (20) | 969 (51) | 39 (7) | 4,760 (17) |
| **Homosexual Male & IV Drug Abuser** | 39 (8) | 2,188 (8) | | | 39 (7) | 2,188 (8) |
| **Hemophilia/Coagulation Disorder** | 5 (1) | 235 (1) | | 7 (0) | 5 (1) | 242 (1) |
| **Heterosexual Cases** | 2 (2) | 542 (2) | 9 (36) | 518 (28) | 11 (2) | 1,060 (4) |
| **Transfusion, Blood/Components** | 13 (2) | 324 (1) | 6 (24) | 184 (10) | 19 (3) | 508 (2) |
| **Undetermined** | 20 (2) | 652 (3) | 5 (20) | 204 (11) | 25 (4) | 856 (3) |
| **SUBTOTAL: Adults/Adolescents** | 539 (100) | 25,961 (100) | 25 (100) | 1,882 (100) | 564 (100) | 27,843 (100) |
| **CHILDREN** | | | | | | |
| **Hemophilia/Coagulation Disorder** | 0 (0) | 21 (9) | 0 | 1 (1) | 0 (0) | 22 (5) |
| **Parent with/at risk of AIDS** | 2 (67) | 162 (73) | 2 | 157 (87) | 4 (57) | 319 (79) |
| **Transfusion, Blood/Components** | 1 (33) | 33 (15) | 2 | 19 (10) | 3 (43) | 52 (13) |
| **None of the Above** | 0 (0) | 6 (3) | 0 | 4 (2) | 0 (0) | 10 (2) |
| **SUBTOTAL: Children** | 3 (100) | 222 (100) | 4 (100) | 181 (100) | 7 (100) | 403 (100) |
| **TOTAL** | 542 | 26,183 | 29 | 2,063 | 571 | 28,246 |

* U.S. numbers from the Centers for Disease Control Weekly Surveillance Report

**TABLE 2 — Diseases at Least Moderately Indicative of Cellular Immunodeficiency (Source: CDC Case Definition of AIDS)**

1. Kaposi's sarcoma
2. *Pneumocystis carinii* pneumonia
3. Toxoplasmosis infection of internal organs other than liver, spleen, or lymph nodes
4. Cryptosporidiosis, intestinal, causing diarrhea for over one month
5. Candidiasis, causing esophagitis
6. Cryptococcosis, causing CNS or other infections disseminated beyond the lungs and lymph nodes
7. *Mycobacterium avium* or intracellular (*Mycobacterium avium* complex) causing infection disseminated beyong the lungs and lymph nodes
8. Primary lymphoma of the brain
9. Progressive multifocal leukoencephalopathy (Papova virus infection, brain)
10. Chronic mucocutaneous herpes simplex infection ulcers persisting more than one month

**TABLE 3 — Known Causes of Reduced Resistance (Source: CDC Case Definition of AIDS)**

1. Systemic corticosteroid therapy
2. Other immunosuppressive or cytotoxic therapy
3. Cancer of lymphoreticular or histiocytic tissue such as lymphoma (except for lymphoma localized to the brain), Hodgkin's disease, lymphocytic leukemia, or multiple myeloma
4. Age 60 years or older at diagnosis
5. Age under 28 days (neonatal at diagnosis)
6. Age under 6 months at diagnosis
7. Immunodeficiency atypical of AIDS, such as one involving hypogamma globulinemia or angioimmunoblastic lymphadenopathy; or an immunodeficiency of which the cause appears to be a genetic or developmental defect rather than HTLV-III infection
8. Exogenous malnutrition (due to starvation, not malnutrition due to malabsorption or illness)

tibody test results, pre and post test counseling regarding the significance of the test is essential. If the physician thinks testing is indicated but does not feel comfortable in providing adequate counseling, the patient should be referred to one of the 11 counseling and testing sites established by DHR, located in the major health departments throughout the state (Table 5).

At the counseling and testing sites, the individual receives educational materials, pretest counseling, and is assigned an identification number. In about 2 weeks, the individual returns to receive post test counseling and test results. Test results are released only with the preassigned identification number in hand. No names are recorded, and all test results are kept strictly confidential. An individual need not necessarily go to the local health department for testing, but may go to a health department where he or she may not be recognized. Persons interested in testing should contact their local health department, the Georgia AIDS Project, or the Georgia AIDS Hotline, toll free at 1-800-551-2728.

### Blacks and AIDS

National statistics indicate that the black population is affected by AIDS at a higher rate than the white population. Blacks constitute 12% of the U.S. population, yet they account for 24% of reported cases. This disproportion is not seen in Georgia. As stated earlier, blacks comprise 26% of the state population and account for 27% of the reported AIDS cases.

Comparing transmission categories in Georgia with the national categories (Table 1), it can be seen that Georgia has a decreased percentage of heterosexual drug abusers (7%), compared to the national percentage (17%). It may be that drug abuse is less prevalent among blacks in Georgia compared to blacks in states such as New York and New Jersey, where large numbers of AIDS cases are located. This could be the reason why Georgia does not have a disproportionate percentage of AIDS cases that are black. Persons are at risk not because of race, but rather because of risk factors.

This racial variance with the national percentages is not seen in pediatric cases. Blacks account for 57% of pediatric cases nationally and 57% of the pediatric cases in Georgia.

The belief among blacks that AIDS is a gay, white, male disease, as well as racial differences in cultural attitudes toward homosexuality, hinders education and prevention practices. Education programs specifically designed for and targeted toward blacks are needed.

### Intravenous Drug Abusers

The greatest influx of AIDS into the general population may come from IV drug abusers with heterosexual contacts. This is the high risk group that has the most potential for spread of HIV infection through both heterosexual contact and vertical transmission (mother to fetus). There is evidence that as a group, IV drug abusers and infants with AIDS have a more virulent clinical course than other high risk groups.

Case control studies have indicated a relationship between the extent of needle sharing and the risk of exposure to the virus. Needle sharing is a relatively new phenomenon among narcotic addicts, as is seen in the current popularity of "shooting galleries" where addicts go to share or rent injection pharaphernalia.[9] Often, the

**TABLE 4 — CDC Classification of HTLV-III/LAV Infection**

**Group I: Acute Infection**
Mononucleosis-like syndrome associated with seroconversion.

**Group II: Asymptomatic Infection**
Positive HTLV-III/LAV antibody or viral culture. May be subclassified on basis of laboratory evaluation (CBC, platelet count, T-cell subset studies).

**Group III: Persistent generalized lymphadenopathy**
Palpable lymphadenopathy (>1 cm) at two or more extrainguinal sites for more than 3 months in the absence of a concurrent illness or infection to explain the findings. May be subclassified on the basis of laboratory evaluation (see above).

**Group IV: Other HTLV-III/LAV disease**

**Subgroup A: Constitutional disease**
One or more of the following: fever or diarrhea persisting more than one month or involuntary weight loss greater than 10% of baseline; and absence of a concurrent illness or infection to explain the findings.

**Subgroup B: Neurologic disease**
One or more of the following: dementia, myelopathy, or peripheral neuropathy; and absence of a concurrent illness or condition.

**Subgroup C: Secondary infectious diseases**
Infectious disease associated with HTLV-III/LAV infection and/or at least moderately indicative of a defect in cell-mediated immunity.

**Category C-1**
Symptomatic or invasive disease due to one of 12 specified diseases listed in the surveillance definition of AIDS: *Pneumocystis carinii* pneumonia, chronic cryptosporidiosis, toxoplasmosis, extraintestinal stronglyoidiasis, isosporiasis, candidiasis (esophageal, bronchial, or pulmonary), cryptococcosis, histoplasmosis, mycobacterial infection (*Mycobacterium avium* complex or *M. kansasii*), cytomegalovirus infection, chronic mucotaneous or disseminated herpes simplex virus infection, and progressive multifocal leukoencephalopathy.

**Category C-2**
Symptomatic or invasive disease due to one of six other specified diseases: oral hairy leukoplakia, multidermatomal herpes zoster, recurrent Salmonella bacteremia, nocardiosis, tuberculosis, and oral candidiasis (thrush).

**Subgroup D: Secondary cancers**
Diagnosis of one or more cancers known to be associated with HTLV-III/LAV infection as listed in the surveillance definition of AIDS and at least moderately indicative of a defect in cell-mediated immunity: Kaposi's sarcoma, non-Hodgkin's lymphoma (small, noncleaved lymphoma or immunoblastic sarcoma), or primary lymphoma of the brain.

**Subgroup E: Other conditions in HTLV-III/LAV infection**
Clinical findings or diseases, not classifiable above, that may be attributable to HTLV-III/LAV infection and are indicative of a defect in cell-mediated immunity; symptoms attributable to either HTLV-III/LAV infection or a coexisting disease not classified elsewhere; or clinical illnesses that may be complicated or altered by HTLV-III/LAV infection. These include chronic lymphoid interstitial pneumonitis and constitutional symptoms, secondary infectious diseases, and neoplasms not listed above.

same needle will be used for up to 50 injections until it is no longer usable. "Shooting galleries" are analogous to "gay bathhouses" in the epidemiology of AIDS. Both provide settings for efficient exposure to the blood and body fluids of large numbers of contacts.

## Economic Impact

By 1991, it has been estimated that Georgia may have as many as 3,000 active cases of AIDS. Another 3,000 persons will have died with AIDS during the first decade of this disease. A study completed by the CDC demonstrates that approximately 50% of the medical care costs of AIDS is borne by the private sector. The same document estimated that the average cost of care for an AIDS patient is between $50,000 and $100,000. Extrapolating from these data, the public cost for the medical care of AIDS patients in 1991, in Georgia, could be from $75 million to $150 million. The Division of Public Health plans to recommend to the Medical Indigency Study Committee of the General Assembly a proposal for identifying the cost factors in order to have more definitive and accurate information in Georgia.

## State AIDS Task Force

In an effort to develop strategies for combating AIDS and minimizing its transmission, the state Board of Human Resources directed DHR to appoint a State Task Force on AIDS. The Task Force, established in the fall of 1985, consists of 23 appointed members, who represent multiple disciplines and the major population areas of the state, as well as five consultants and 10 resource persons. Dr. Douglas Skelton, Dean of the Mercer University School of Medicine serves as chairman. (See his accompanying article in this issue.)

## Current Studies

The Georgia AIDS Project is currently involved in the development and/or implementation of four epidemiologic studies designed to pro-

**TABLE 5 — HIV Counseling and Testing Sites**

| | | |
|---|---|---|
| Fulton County | Atlanta | (404) 572-2201 |
| Floyd County | Rome | (404) 295-6151 |
| Hall County | Gainesville | (404) 535-5438 |
| Troup County | LaGrange | (404) 884-8673 |
| Bibb County | Macon | (912) 744-6214 |
| Richmond County | Augusta | (404) 724-4214 |
| Muscogee County | Columbus | (404) 327-7495 |
| Dougherty County | Albany | (912) 356-2157 |
| Chatham County | Savannah | (912) 356-2157 |
| Clarke County | Athens | (404) 542-8600 |
| DeKalb County | Decatur | (404) 294-3766 |

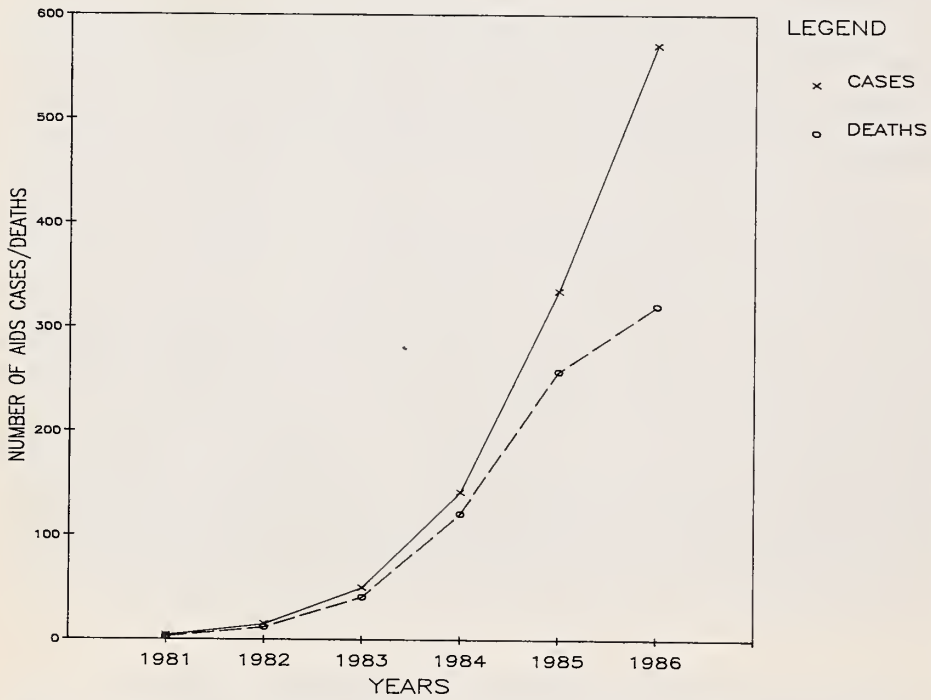


*Figure 4 — Reported AIDS Cases in Georgia, July 1981-December 1, 1986. Total Cases: 571. Total Deaths: 321.*

vide information on the prevalence of AIDS in Georgia. The studies are to determine:

1. The rate of HIV antibody seropositivity among females who deliver babies in the Atlanta tertiary obstetrical care center.
2. The HIV antibody seropostivity among Public Health STD Clinic patients.
3. The HIV antibody seropositivity prevalence among female prostitutes in Atlanta, Georgia (in conjunction with the CDC).
4. The HIV antibody seropositivity among IV drug abusers attending methadone clinics.

## Discussion

It is apparent, especially to those physicians who treat large numbers of AIDS and ARC patients, that only the "tip of the iceberg" is being reported. It is estimated that for every reported AIDS case, there may be 10-25 cases of ARC, many of them very sick and some of them dying without meeting the official reporting definition. This tends to give a false picture and to minimize the public health problem in terms of the risk of spread, as well as suffering, death, and economic costs. An official definition of ARC is needed so that physicians can report these cases as well. Then a more realistic view of the epidemic will be apparent.

***"Due to the serious potential for social and psychologic harm to individuals resulting from positive HIV antibody test results, pre and post test counseling regarding the significance of the test is essential."***

The only means to prevent AIDS is by education of the general public.[10] The physician has a very important role in this. Patients must be educated as to the dangers of sexual promiscuity and drug abuse. The physician has a new and vital reason for taking a detailed sexual practice and lifestyle history, especially of their sexually active single male and female patients.[11] These people, usually young, must understand that AIDS is a risk for everyone who is promiscuous — not only for the homosexual or bisexual male or the IV drug abuser, but also for the heterosexual with more than one sex partner. Physicians should tell their patients that engaging in sex indiscriminantly is potentially lethal. The spread from male to female by penile-vaginal sex is a fact. Therefore, the sexually active woman is at high risk whenever she engages in vaginal intercourse with someone who, unknown to her, may be a member of a high risk group. Female-to-male spread by vaginal intercourse has been reported and appears to be com-

mon in Central Africa. As yet, this type of spread seems to be rare in the U.S.

The message is clear. Patients, male and female, must be told that the so-called "sexual revolution" and the era of the "one night stand" is over.

***"Persons interested in HIV antibody testing should contact their local health department, the Georgia AIDS Project, or the Georgia AIDS Hotline, 800-551-2728."***


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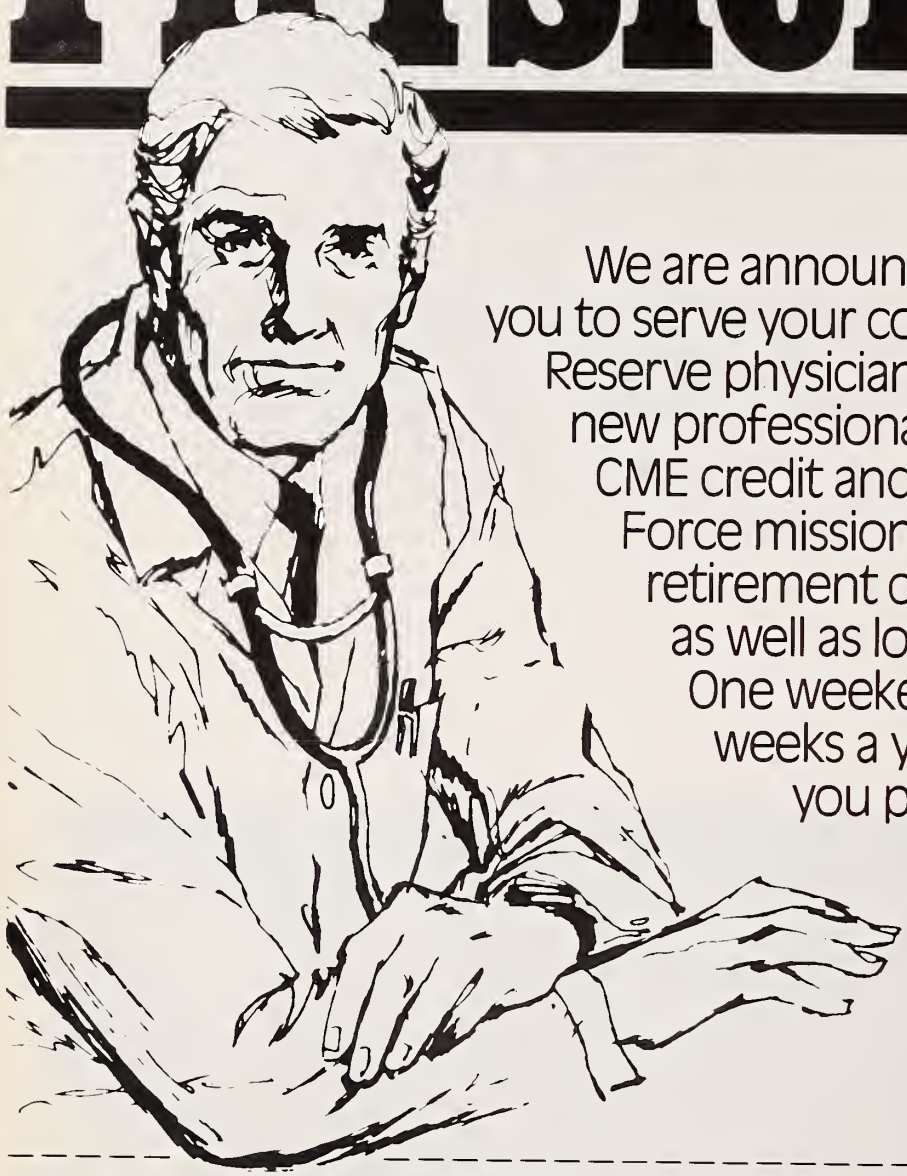

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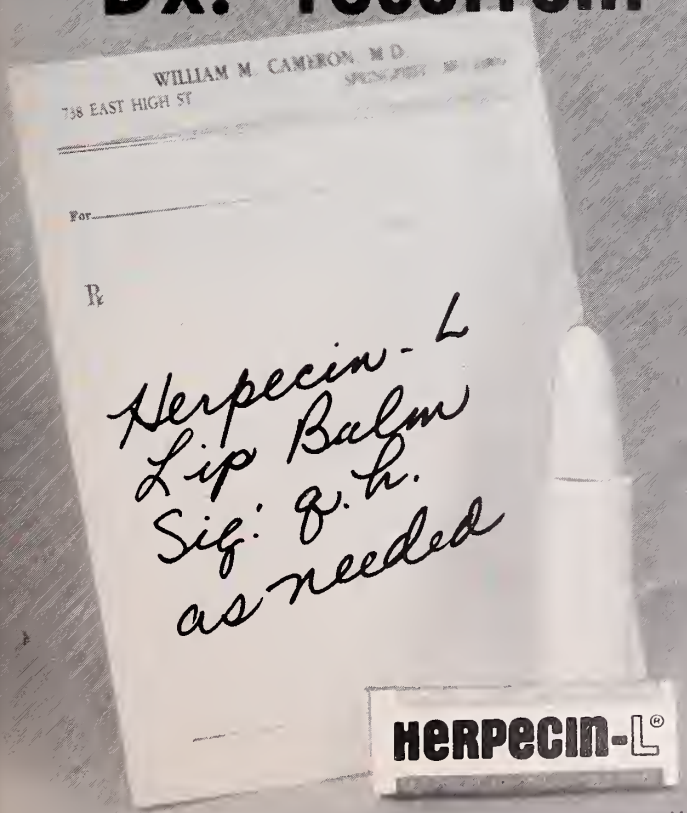


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# PSYCHOLOGIC ISSUES RELATED TO AIDS

ROBERT L. BLANEY, PH.D., GARY E. PICCOLA, PH.D.

**Abstract**

*This article addresses the emotional reactions at the time of diagnosis of AIDS and follows with a discussion of the experiences of living with this disease. The psychologic issues of physicians who treat AIDS patients are also considered. Our discussion concludes with a look at the implications of this disease for mental health services.*

## Introduction

THE PSYCHOLOGIC issues confronting a person diagnosed with AIDS are similar in many ways to the issues faced by anyone diagnosed with a disease likely to be fatal. Facing death before completing the expected lifespan usually includes reactions of anger, denial, grief, and depression. A person's emotional experience facing an early death is determined by a number of factors, including the nature of one's mental health prior to the diagnosis of the disease and the quality of life possible in the remaining lifetime.

Although there are common features between the emotional reactions to a diagnosis of AIDS and a diagnosis of any potentially fatal disease, there are also factors unique to AIDS. These factors often compound the distress experienced by the AIDS patient. The concentration of this disease within certain populations, namely male homosexuals and IV drug users, has contributed to a popular regard of AIDS as a stigmatized disease. Individuals who live with AIDS must face family, friends, and co-workers with an affliction associated with stigmatized minority groups.

In addition to the stigma attached to AIDS, the relative newness of it and the fact that much about it is still not well understood contribute to the emotional distress of a person with AIDS. Widespread coverage of AIDS by the media, presenting an alternatively hopeful and pessimistic picture, often increases this distress. The many variations in the course of the disease and in the quality of life possible during this time cause uncertainty and present practical and emotional issues to be confronted.

In this article, we address some of the major psychologic issues facing the AIDS patient. No attempt has been made to address the psychologic issues of persons with AIDS-related complex. The issues for this population are often different and even more complex than those for AIDS patients. Much of the content of this article is drawn from experience, our own as providers of psychologic services to AIDS patients and from the experiences of colleagues in the medical community with the same population. In nearly all cases, the person with AIDS was an adult homosexual male. This fact raises the question of the degree to which our findings can be generalized to a wider population.

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## Reactions To Diagnosis

Individual responses upon hearing a diagnosis of AIDS from a physician will vary. For many, the diagnosis may confirm what was feared already. For others, hearing that they have AIDS will be experienced as a shock. Often the initial reaction in the doctor's office appears relatively calm. As the patient realizes the probable consequences of his disease, reactions change, usually toward increased anxiety.

In some cases, persons hearing of their diagnosis may appear relieved to finally learn the cause of an often bewildering course of illness. Such relief is brief and soon replaced by feelings of anxiety or depression. In other instances, an individual's reaction to the diagnosis will be one of confusion. Confusion usually arises from the individual's poor understanding of previous and/or concurrent illness, and the relationship of the illness to AIDS. Some people may

not accurately comprehend the nature of AIDS and its implications.

The symptoms leading to the diagnosis are often predictors of a person's emotional reaction to the diagnosis. Persons who learn of their condition as indicated by Kaposi's sarcoma, for example, may be experiencing a sense of relatively good health otherwise. The reaction of these patients is often denial of the implications of their diagnosis. Denial is supported by the ability of these individuals to continue, for some time, to live a comparatively normal life. Although they may experience anxiety and depression, the ability to continue functioning normally at work as well as socially can help decrease the frequency of extreme mood fluctuation.

Individuals who are seriously ill with opportunistic infections at the time of diagnosis are most likely already in a depressed mood. Denial is less likely in these individuals at the time of diagnosis, although mood fluctuations occur as symptoms of infections are alleviated. The experience of serious illness prior to diagnosis can diminish reactions of anger and denial.

In some cases, the diagnosis will result in both denial of the disease and inappropriate acting out behavior, as diagnosis disinhibits mechanisms of control. Reactions may consist of behavior such as sexual promiscuity, use of recreational drugs, or indiscriminate spending. These behaviors, manifestations of both anger and denial of the disease, are often difficult to manage. Reactions of this sort are usually the result of pre-existing emotional disorders.

### Living with AIDS

Learning to live with AIDS is in many ways like adjusting to any chronic and life-threatening illness. The individual must come to understand the nature of his disability and must make changes in his lifestyle accordingly. For example, many persons with AIDS will no longer be able to sustain full or even part-time jobs, and practical issues of finances and health care will need to be addressed. Those who cannot work may find themselves with a great deal of unstructured time. The variability and unpredictability of the course of the illness, however, make it difficult for the individual to make commitments involving time. Thus, the individual may be dealing with long periods during which he is alone, sometimes home-bound, bored, ill and lonely. In addition, loss of career may mean the loss of a major source of the individual's self-esteem and identity.

***"In terms of emotional issues, the person with AIDS may need assistance in understanding the intensity of his emotional responses."***

AIDS differs from other serious illnesses, however, in ways that are related to the nature of the disease itself and to characteristics of the individual. First, AIDS by definition is a disease of personal vulnerability; the person with AIDS is likely to be experiencing a sense of mistrust of his body. Hitherto ignored physical symptoms and sensations suddenly become potential signals of opportunistic infection and, hence, a source of anxiety and possible alarm. In this context, hypervigilance that might otherwise be associated with hypochondriasis becomes adaptive. On the other hand, some patients may deal with this source of anxiety through denial, ignoring symptoms for fear that they signify a fatal infection. The sense of personal vulnerability may also extend to issues concerning physical proximity to other people. Responses may range from total phobic avoidance of others to reckless self-exposure to potentially illness-inducing situations.

As a contagious disease that has unfortunately been compared to the

***"Although there are common features between the emotional reactions to a diagnosis of AIDS and a diagnosis of any potentially fatal disease, there are also factors unique to AIDS."***

*“In many ways, AIDS presents the individual with a personal/existential challenge to which he may respond with a depressive reaction and with concomitant symptomology, or with an awakened sense of purpose and rededication to life. Some persons with AIDS, for example, react to their diagnosis by becoming politically active or involved with AIDS service organizations, channeling their grief into productive activities and care for others.”*

Plague by the media, AIDS may also elicit feelings of self-loathing and rejection. Some AIDS patients may experience themselves as unclean or dangerous, particularly if they lack sufficient knowledge about transmissability. Since a major mode of transmission of the virus is through semen, an important focus of concern is the area of sexual expression. Individuals in long-term relationships may fear infecting their partners and may withdraw from all intimate contact. Those not in ongoing relationships may experience confusion or uncertainty about the role of sexuality in their lives and about the possibility of establishing intimate relationships. Anger is not an uncommon reaction to the perceived loss. Many persons with AIDS report not having been touched or held affectionately since their diagnosis, and thus have not experienced an important source of comfort and acceptance.

The link between AIDS and the homosexuality of the persons we are discussing complicates the psychodynamic picture. Unresolved issues concerning self-acceptance are likely to re-emerge. Guilt about homosexual behavior may lead some persons with AIDS to believe that the illness is punishment for perceived past transgressions. A re-examination of religious beliefs is not uncommon, especially if a reconciliation between gay identify and religious background has not been previously attained. The relative youth of many of the men also contributes to the emotional complexity of AIDS. An individual in his twenties, for example, has probably not resolved developmental issues concerning identity, much less assimilated an awareness of his own mortality. For this person, what is grieved may be the life that will not be lived, the goals that will not be achieved.

*“In some cases, patients hearing of their diagnosis may appear relieved to finally learn the cause of an often bewildering course of illness.”*

Thus, in many ways, AIDS presents the individual with a personal/existential challenge to which he may respond with a depressive reaction and with concomitant symptomology, or with an awakened sense of purpose and rededication to life. Some persons with AIDS, for example, react to their diagnosis by becoming politically active or involved with AIDS service organizations, channeling their grief into productive activities and care for others. Many speak of appreciating life and of finding new meaning in their relationships with life partners, families, and friends. For some, AIDS provides an opportunity for self-assessment, redefinition of values and goals, and emotional and spiritual growth.

### AIDS In A Social Context

How a particular person reacts to AIDS will be a function of his unique personality structure, personal history, health status, and quite importantly, the interpersonal network within which he lives. As with other diseases, the scope and strength of an individual's social system will often affect the manner in which he copes with his illness. As a disease associated with stigma, as well as with stigmatized minority groups, however, AIDS often represents the person with the possibility of rejection by those closest to him. People with AIDS have been blamed for their illness, rejected by their families and friends, and abandoned by their partners. Sometimes, when most physically challenged or weakened, a person with AIDS may find himself dealing with isolation and loss.

The family of a gay person with AIDS can present complicated emotion-laden interpersonal dynamics. In some instances, family members may be learning that the individual with AIDS is gay at the same time that they are trying to assimilate that he is se-

riously ill and possibly dying. Families may be called upon to interact with a gay support system previously unknown to them, or to accept intimate relationships previously devalued or, in some cases, abhorred. The right to make decisions about patient care and post-death arrangements can be a source of conflict between the individual's mate and his family of origin. Unfortunately, the needs and wishes of the person with AIDS may not always be respected.

***"Beyond assessment, the two primary aspects of mental health care for AIDS patients are information and support."***

From the standpoint of the person with AIDS, then, the individual's support system may be a source of anxiety or a source of comfort. He may or may not be able to rely upon homosexual friends, as they may feel threatened due to their own perceived vulnerability. On the other hand, this same identification with the person with AIDS may generate empathy, concern, and physical and emotional support. Certainly on a wider level, the response of the gay community to the needs of persons with AIDS has been compassionate and generous.

**Physician's Reactions**

It is well known that caring for a patient with a potentially fatal disease creates a great deal of stress, particularly when the patient population is relatively young. Personal reactions to the patient and to the disease will occur and are to be expected.

Treatment of AIDS patients may create an emotionally uncomfortable situation that has not been experienced previously by the physician. One source of this discomfort can be demands placed upon the physician by the rapidly changing state of medical knowledge regarding the disease. Another may be difficulties imposed by the diagnosis and treatment of heretofore relatively little known infections. These professional challenges may occur at the same time a patient with AIDS needs to depend upon the physician as a source of support and authority. Perhaps the greatest emotional discomfort comes from the fact that death from AIDS often occurs after a patient has experienced intense long-term physical and emotional suffering. Witnessing this suffering and death can elicit intense emotional reactions that may include feelings of helplessness, sadness, and even rage.

The nature of this disease will undoubtedly elicit emotional reactions in any physician responsible for the care of such a patient. This fact raises the question of whether or not every physician may wish, or be suited, to undertake the responsibilities of treatment of such patients. The role of the physician-patient relationship to the patient's sense of well being is well documented. This fact suggests that any physician experiencing intense negative feelings toward the treatment of an AIDS patient may need to consider whether to continue in the role of primary physician. In cases where adjustments have taken place for these reasons, both physician and patient appear to benefit.

***"Treatment of AIDS patients may create an emotionally uncomfortable situation that has not been experienced previously by the physician."***

Individuals diagnosed as having a fatal disease may turn to alternative health care models in the hope that there may be a cure outside the traditional medical community. Tech-

***"Any physician experiencing intense negative feelings toward the treatment of an AIDS patient may need to consider whether to continue in the role of primary physician."***

*“No matter what therapeutic setting or modality is chosen, an awareness of the psychologic complexities of AIDS, the nature of grief, and a sensitivity to the emotional experience of the person with AIDS are exquisitely important.”*

niques that include visualization and imaging have been used with cancer patients; other techniques include nutritional regimens. These techniques have also been used by AIDS patients. As adjuncts to traditional medical care, they seem to do no harm. Often, these techniques appear to enhance the quality of life experienced by the AIDS patients, contributing to an improved sense of well being. The effects of such techniques may be regarded skeptically by the medical community. However, in view of the fact that such methods rarely interfere with necessary medical treatment, and in fact enhance the quality of life for a person with AIDS, tolerance by physicians of such techniques should perhaps be encouraged, if no conflict arises with necessary medical care.

**Implications For Mental Health**

The single best predictor of the mental health of a person diagnosed with AIDS is probably the mental health of that person prior to the onset of disease. As noted previously, individual reactions to the diagnosis will vary, but the possibility of extreme emotional reactions to the disease is increased in those experiencing prior emotional difficulties. Assessment of mental health status can yield information helpful to identify those persons at greatest risk to act out, commit suicide, or otherwise endanger themselves or others.

Assessment may be complicated by the manifestations of the disease. Infections of the central nervous system as a result of AIDS will often affect both mood and cognitive functioning. Extreme depression and/or thought-disorder may not only be emotional reactions to the disease but also be the result of organic impairment as a consequence of infection. The fatigue and anorexia associated with AIDS itself may be mistaken for or may mask underlying depressive reactions.

Beyond assessment, the two primary aspects of mental health care for AIDS patients are information and support. Throughout his illness, the AIDS patient will need practical information concerning the impact of the disease on the quality of his life. He may need guidance in learning to structure his time or in finding meaningful alternatives to work. He may have specific concerns about self-care or about sexuality that will need to be addressed, as will concrete plans concerning finances, care, and funeral arrangements.

In terms of emotional issues, the person with AIDS may need assistance in understanding the intensity of his emotional responses, and in working through the grief process. He may need to resolve guilt about past behavior or about his homosexuality, as well as support in dealing with possible antagonism within family or community. For some, loss of interpersonal support and/or isolation will need to be addressed.

In some instances, all of these issues will be sufficiently addressed by partners, friends, and family of the person with AIDS, as well as by primary medical caregivers. If such is the case, no need for professional mental health consultation may exist. In cases where the natural support system is non-existent, conflicted, or inadequate, or where the individual presents with serious psychiatric symptomatology, referral to a qualified mental health practitioner may be appropriate. Group counseling experiences with other persons with AIDS, such as those offered by AID-Atlanta, appear to be especially effective in providing practical information as well as reducing interpersonal isolation and anxiety. The person with AIDS may need assistance in order to contact these resources or to deal with resistance to such contact.

Individual psychotherapy may be helpful in resolving identity and guilt issues and in facilitating the grief work. On occasion, couple or family psychotherapy may be indicated to help the natural support system work more effectively. No matter what therapeutic setting or modality is chosen, an awareness of the psychologic complexities of AIDS, the nature of grief, and a sensitivity to the emotional experience of the person with AIDS are all exquisitely important. ■

# Meeting the Mental Health Challenge of AIDS and Related Disorders

Sarah W. Holmes, M.A., Jesse Peel, M.D.

**Abstract**

**An examination of the requests for services received by AID Atlanta, a non-profit organization which provides services to people with AIDS and their families, indicates a great need for services provided by health professionals who are thoroughly familiar with HIV infection, its spectrum of symptoms, and its psychosocial implications. AID Atlanta has developed a program which seeks to provide this training to large numbers of health professionals during 1987. Specific information about the details of this program can be obtained from AID Atlanta, 811 Cypress Street, Atlanta, GA 30308 (404)872-0600.**

As the number of persons with AIDS, Aids-Related Complex (ARC), and those who are HIV antibody positive (the "worried well") increases, there has been a corresponding increase in the need for services by health professionals who are thoroughly familiar with HIV infection, its spectrum of symptoms, and its psychosocial implications. An examination of the requests for services received by AID Atlanta, a non-profit organization which provides supportive services to persons with AIDS and ARC and their families, as well as AIDS education to the general public, indicates that there is currently a widespread need for supportive mental health services among those directly affected by AIDS. As of November 30, 1986, a total of 400 people with AIDS or ARC had requested services from AID Atlanta. For each of these, an average of 3 others (e.g., family members, partners, close friends) also requested some form of supportive service. State epidemiologists expect the AIDS caseload to double each year through the end of the decade. It is thus likely that by the end of 1989, there will be 4000 cases of AIDS and 40,000 cases of ARC in metropolitan Atlanta alone. The numbers of the "worried well" could reach 400,000.

To meet the challenge presented by these figures, most if not all health professionals, from physicians to psychologists to nurse's aides, must acquaint themselves with the medical and psychosocial implications of HIV infection. The Patient Services Staff of AID Atlanta has found that receiving health care from professionals who are thoroughly familiar with AIDS is extremely important to the majority of their clients, as knowledgeable medical personnel are less likely to treat their patients in ways which increase the feelings of isolation and helplessness that so often accompany this disease. Thus, well-informed professionals can affect not only the patient's and family's adjustment to the diagnosis, but also the quality and length of life.

There is also a great need for services from mental health professionals who are familiar with all aspects of HIV infection. To date, 46% of AID Atlanta's clients have requested services in the form of support groups for themselves and/or family members, and 19% have requested individual counseling or therapy. Persons with AIDS and ARC

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often seek the services of mental health professionals to help them cope with the stress that accompanies the diagnosis, to deal with death and dying issues and to deal with real and anticipated rejection and social isolation. A growing percentage of AIDS patients require psychiatric intervention and/or hospitalization as a result of neurologic impairments and cognitive dysfunction stemming from several of the AIDS-related infections.

***"The Patient Services Staff of AID Atlanta has found that receiving health care from professionals who are thoroughly familiar with AIDS is extremely important to the majority of their clients (so as not to) increase the feelings of isolation and helplessness that so often accompany this disease."***

Family members often request counseling and support to help them accept the diagnosis, to deal with their own fears of ostracism, and to learn to be supportive. Grieving loved ones often need support in their bereavement. Those who are HIV antibody positive but who are not sick sometimes need counseling to cope with their fears of developing ARC or AIDS and the anxiety produced by knowledge of their positive status.

For these needs to be met now and in the future, adequate training and education must be provided for large numbers of health professionals. Unfortunately, an informal survey of Atlanta health professionals indicates that such knowledge is not widespread, particularly among mental health professionals. In an effort to assist in the provision of this much needed training, AID Atlanta has created a 1-year program aimed at providing a thorough overview of all aspects of HIV infection to interested health professionals. While mental health professionals have been specifically targeted by this program, the training package is available to all health professionals.

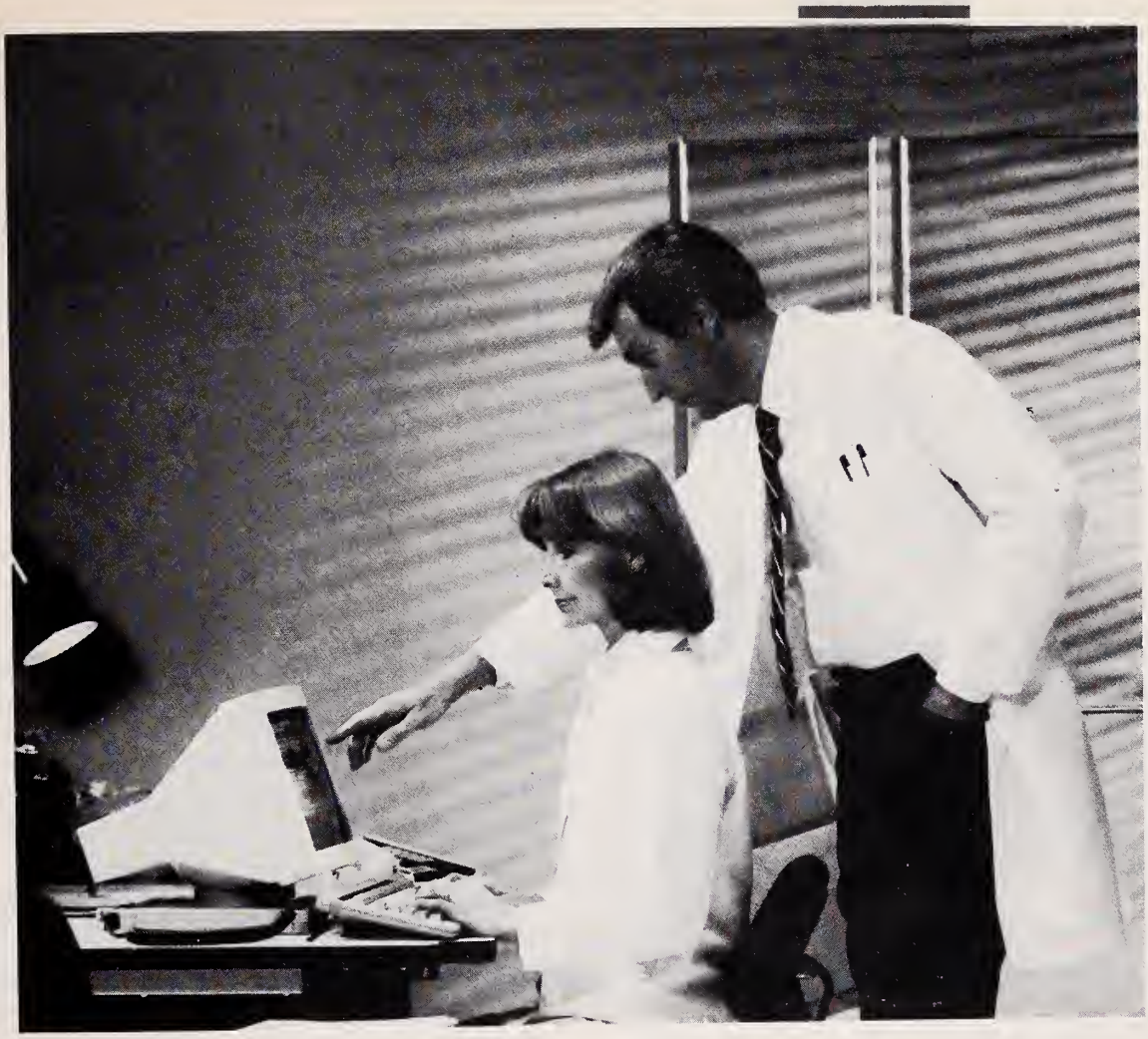
AID Atlanta is experienced in providing in-services, seminars, and weekend training workshops which combine medical and psychosocial information with first hand experience, as all trainings are delivered by professionals directly involved in the care of persons with AIDS and ARC and their loved ones. Since September, 1985, AID Atlanta has conducted six 2-day comprehensive training workshops and 42 in-services or seminars at hospitals, treatment centers, and other medical facilities or organizations. While the in-services are geared toward the needs of the specific audience, all provide an overview of medical and psychosocial information as well as clinical case illustrations. The 2-day workshops also include segments on death and dying issues, panel discussions with AIDS and ARC patients, health care professionals, etc.

AID Atlanta has drawn on this experience to create the current program for health professionals. The goals of the program include measuring the awareness of AIDS-related issues among health professionals in metropolitan Atlanta, increasing the number of health professionals across the state who are familiar with HIV infection, its spectrum of symptoms and psychosocial implications, and expanding the pool of psychiatrists, psychologists, and social workers who are available to serve AID Atlanta clients at reduced fees.

***"AID Atlanta has created a 1-year program aimed at providing a thorough overview of all aspects of HIV infection to interested health professionals."***

Specific objectives have been set for meeting these goals. These include providing training to at least 600 mental health professionals as well as other health professionals, and providing in-depth, issue-oriented training to at least 100 professionals. To achieve these objectives, AID Atlanta will sponsor 2-day training workshops geared specifically toward health professionals, deliver trainings at conferences and professional meetings, deliver in-services at group practices and institutions, and provide one day follow-up workshops which focus on specific clinical issues. This program is being overseen by an advisory board comprised of physicians, clinical psychologists, and clinical social workers.

It is AID Atlanta's hope that large numbers of health professionals will avail themselves of the training opportunity offered by this program. Detailed descriptions of the content of week-end training workshops as well as the shorter versions delivered in seminars and in-services are available through AID Atlanta, 811 Cypress Street NE, Atlanta, Georgia 30308. ■



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# AIDS In *My* Practice?

Brigette B. Nahmias, M.D.

THE PRIMARY CARE physician, in addition to the many pressing duties of office practice, has another problem to worry about now — the AIDS epidemic.

*"Not in* my *practice!"*

*"Well, I haven't seen a case yet and I hope I never do."*

*"Come on — we don't have that kind of patient here."*

The HIV (human immunodeficiency virus) is probably in our practices now.

*"Oh, I don't think so."*

*"Frankly, I think this whole thing is blown up out of all proportion."*

*"We don't have any gays in our practice as far as I know and certainly no drug addicts."*

So begins a videotape for primary care physicians with the same title as this article, which is currently under preparation under a grant from the C.D.C.

For most of us, AIDS is still an exotic disease. We have heard much talk about it, we have seen television news and movies about it, we have read about it in the newspapers and in magazines, but we have never or rarely seen a case. It is a bit like rabies — a dreadful disease, but rarely encountered in ordinary practice.

Only infectious disease specialists, physicians treating many sexually transmitted diseases, those in large cities, those seeing patients of low socioeconomic status and openly gay physicians have seen AIDS. They have already seen so many young people gravely ill, such complicated opportunistic infections, and so many deaths that they are beginning to be overwhelmed and burned out.

Many of us in suburban practices, in subspecialties, in academic or administrative positions feel that AIDS is still a bit remote from our everyday reality.

Yet almost certainly there are some persons now in *every* practice who are carrying the AIDS-causative virus, HIV (formerly known at HTLV-III/LAV). These persons are at risk for developing AIDS and, more importantly, these infected persons are contagious, even though they (and the physician and office staff) may not be aware of it.

***"Many of us in suburban practices, in subspecialties, in academic or administrative positions feel that AIDS is still a bit remote from our everyday reality."***

How can we identify these patients? How do we question them in a sensitive manner in order to elicit the information we need to obtain and they need to share with their doctor? What do we look for in their presentations? How do we advise them? What about their contacts? How do we protect ourselves and our staffs from inadvertent exposure? How do we counsel our community if asked for expert advice?

These questions will be addressed more effectively in the upcoming videotape, which will show actual office situations with experienced physicians

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demonstrating how they handle these problems. In the meantime, here are some guidelines for our consideration.

Underlying every patient encounter must be our awareness that the HIV has already infected many Americans, male and female, adult and child, gay or straight. Gay men are the population which was first affected in Western countries, and 60-90% can be considered to be infected, the greatest proportion among those with many sex partners. But any man who has had even *one* homosexual encounter since 1979 is at risk. It is estimated, based on the Kinsey report, that approximately 10% of American men have had a homosexual experience. Therefore, we are dealing with large numbers. In small communities, most gay men have probably not "come out" and may even be married, putting their wives and future children at risk. What are some pertinent clues? There are few, beyond the more obvious one: a single man in his 20s, 30s, 40s or 50s. It is more important, in order to elicit the pertinent history, to ask questions in an open, non-judgmental manner which invites confidence and trust.

### Taking Histories

A sexual history now has to asked of *all* our patients and can begin with, "Are you sexually active?" If the answer is "yes," we continue when appropriate with, "Is your lifestyle straight or gay?," assuring the patient that confidentiality is a matter of principle with us and our staff. If the answer is "gay," we need to be prepared to ask about current and previous partners, past sexually transmitted diseases (STDs) — a good marker for type and extent of sexual activity — about knowing anyone with AIDS or anyone "exposed," a common euphemism for someone infected and having a positive blood antibody test.

Whether straight or gay, male or female, we need to ask about sexual exposure to someone from an area where the incidence of AIDS is high, e.g., one of the central African countries, Haiti, the Caribbean, or any large Western city.

Has there been any drug use, including poppers, cocaine, other "recreational" drugs, and particularly "shooting up"?

What about the patient's concerns? Is s/he worried about exposure? About any symptoms? Has s/he lost weight or energy? Does s/he have a chronic cough, fever, nightsweats — all indicators of infection, particularly PCP (*Pneumocystis carinii* pneumonia), tuberculosis, and atypical mycobacteriosis? Has the patient developed the purplish spots of possible Kaposi's sarcoma? Are there current symptoms of a possible STD: hepatitis, gonorrhea, syphilis, chlamydia, herpes? Does s/he have diarrhea? Are there changes in memory or neurologic function?

### Physical Examination

The physical examination should include a careful check of the skin, including scars of zoster and fungus infection in the axillae and groin, lymph nodes, mucous membranes for moniliasis, retinae for CMV lesions, chest auscultation and rectal exam, looking particularly for fissures and condylomata.

The laboratory tests depend, of course, on your initial impressions and may include CBC, looking for low WBC, platelets and RBC, Sedimentation rate, VDRL, chest x-ray, cultures of stool, and checks for ova and parasites. A multitest for anergy (TB etc.) is helpful.

### Testing for AIDS

The conclusive test is the HIV antibody test. The ELISA test is readily available, inexpensive, and

accurate. But there are enormous problems associated with it politically and emotionally. Most gay men have been strongly influenced against taking the test for fear of job and social discrimination. "No test is best" is the general gay position, although a shift from this hard-line stance is beginning. If we and the patient feel that taking the test is the sensible thing to do, let us remember that test results may not remain confidential, especially in a small community. Completely anonymous testing (the person's name is not recorded, only a number) is available throughout Georgia in 11 cities. The local health department has details. More information is available by calling: 1-800-551-2728. When we refer a patient to a "testing and counseling site," the patient will first speak to a counselor who explains the testing and its meaning, stressing that a positive test does not necessarily mean AIDS, and hopefully stressing the necessity for "safer sex" practices, no matter what the test results might show.

***"Whether straight or gay, male or female, we need to ask about sexual exposure to someone from an area where the incidence of AIDS is high, e.g., central Africa, Haiti, the Caribbean, or any large Western city."***

Then there is an average wait of 2 weeks before the results are available, and these are obtained from the counselor by asking for them by number. However, only one-third of the people with positive test results have returned in Georgia to find out their results and, of course, there is no way to contact the others to inform them. It is clear that primary care physicians will have to be able to advise, counsel, and sustain their patients. It is sometimes difficult for those of us not yet directly at risk to understand the patients' reluctance to take the test. But if we consider the dismal outlook for the future a positive test would imply for the rest of *our* lives, not only in regard to AIDS-related infection, but also the nervous system implications, the possible social stigma, the suffering and financial depletion, and the absence of definitive treatment, perhaps we would not want to know for sure either. As physicians, we want to be supportive and healing, understanding of human weaknesses, just as we are with diabetics who eat too much or emphysematous patients who continue to smoke.

### Counseling Patients at Risk

How do we counsel the patient who is at risk according to the history, whether confirmed by other tests or not?

We give advice which will a) protect the patient's immune system from further insults and b) protect others from transmission of the virus. The foremost advice is to either abstain from sexual intercourse if that is possible or to practice "safer sex." The details are already known to most patients from extensive media coverage, but a firm statement from us may act as the "prompt" to institute such a change in personal behavior. Condoms must be used, oral and genital contact with blood (rectal, menstrual, shaving, toothbrush-induced and other) must be avoided, as well as contact with semen and cervical and vaginal secretions. The Georgia AIDS Infoline:1-800-551-2723 can provide specific information through trained counselors and printed material. For physicians, the national C.D.C.-staffed hot line is particularly helpful, since the staffers will send lots of useful printed material, including reprints of AIDS-related medical literature and a bound volume of pertinent *MMWRs*. That phone number is: 1-800-447-AIDS. In Atlanta, the same persons are reached by calling 329-1295.

A woman at risk should avoid pregnancy (if we say "delay pregnancy" it does not sound as final), since the chance of the baby being infected perinatally is 25-70% for the first baby and about 66% for the second baby. Most infected children die before the age of 2 years, having lived their brief lives in illness and suffering. Obviously, any uninfected woman who is intimate with any man who has had a risky encounter is now taking a terrible chance, not only with her own health and life, but also with that of any future child, unless she and her partner decide to have more definite information by taking the antibody test.

All patients we consider at risk and possibly infected should also be counseled against donating blood, semen, organs. We should ask them to inform family and friends that they do not wish to donate organs and to delete any such notation on their driver's licenses.

As a matter of responsibility, patients at risk should also be asked to inform any other health providers that they may be virus carriers, so that these persons can take proper precautions. These include dentists, dental hygienists, optometrists, nurses, and other physicians. The precautions are the same as for hepatitis and therefore familiar to health workers.

***"How do we counsel the patient who is at risk according to the history, whether confirmed by other tests or not?"***

All our patients, but especially those at risk for AIDS, deserve general advice concerning good health. This includes good diet (avoiding fads and unbalanced high-protein diets), good hygiene, moderate exercise, relaxation techniques, and avoidance of anabolic steroids and recreational drugs. Most importantly for all our patients, whether already infected or not, is the realization that every new sexual encounter is taking a chance, a chance at a fatal illness. Even if already infected, another dose of the virus or of another STD may cause immune system overload.

Of course, needle-sharing by IV drug users confers the same risk as sexual intimacy. The IV drug user population is not an easy one for most of us to deal with, but we need to obtain the history and provide advice and support. Sufferers from AIDS and antibody-positive persons are disproportionally higher among minorities, especially in large inner cities; and many infected babies are born to mothers who either use drugs themselves or have been infected by having sex with a drug-using man.

Another group of patients at risk, although of smaller degree, includes anyone who has had a blood transfusion, or any blood product, especially before March, 1985, when screening went into effect.

And we need to remember that men who have been with a prostitute (business travelers for instance), especially in any of the high-incidence areas, are also at risk and require the same counseling. Studies of wives of infected hemophiliacs and comparisons of infected prostitutes, non-promiscuous wives, and young men in central Africa, over several years, demonstrate a rapid spread in the heterosexual population.

In regard to our office staff, we need to make it clear that the HIV may be present and that it cannot be predicted which patient might be a carrier. It is therefore prudent to avoid contact with blood or semen of any patient. Although transmission from sweat, saliva, tears or urine has not been demonstrated, it would be wise to wear gloves if any cuts or open skin lesions are present on the hands. Otherwise, usual good hand-washing hygiene is used.

HIV is probably already here, in our practices. There is no vaccine. There is no treatment. Forgetting non-solutions such as ignoring the threat, fixing the blame, or expecting quick medical solutions, we can instead make a positive contribution. We can do this by being aware of the problem, by educating ourselves, our staffs, our patients, and our communities. We can remember to question every patient sensitively, to include questions on sexual history, travel, and transfusions, to observe well, and to counsel responsibility for personal practices which will help curb the spread of the AIDS epidemic.

***"The ELISA test is readily available, inexpensive, and accurate. But there are enormous problems associated with it politically and emotionally."***

The questions raised in this article will be addressed by experienced physicians on the upcoming videotape, featuring typical office situations. The tape will be made available free of charge as long as funds permits and thereafter at cost (tape, duplication and mailing), to MAG physicians or contact:

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# THE GEORGIA TASK FORCE ON AIDS

W. DOUGLAS SKELTON, M.D.

*A summary of the Task Force's Reports and Recommendations.*

In August or early September of 1985, I was called by Dr. Ben Okel, Chairman of the Board of Human Resources, who expressed the concern of the Board of Human Resources that Acquired Immunodeficiency Syndrome (AIDS) had become a major health problem in Georgia. Dr. Okel further stated the Board's concern that at the time Georgia had the ninth highest incidence of AIDS cases in the United States and that the number of reported cases was doubling every 9 months. He asked me to chair a Task Force on AIDs which would be appointed by Commissioner Ledbetter and charged with determining the strategies needed in Georgia to combat the disease and minimize its transmission.

On September 18, 1985, the Board of Human Resources passed a resolution directing the Department of Human Resources to appoint what is now referred to as the AIDS Task Force. The Department, under the leadership of Commissioner Jim Ledbetter and Director of Public Health, Dr. Jim Alley, moved rapidly to appoint a multidisciplinary Task Force of 23 members, 5 consultants and 10 resource persons. They were selected in an effort to assemble among the Task Force members, the consultants, and the resource persons a high level of professional expertise regarding AIDS and its means of transmission; governmental leaders responsible for assessing and responding to Georgia's health problems; health care workers concerned about the care of AIDS patients and the protection of themselves and their other patients; representatives from various organizations concerned about AIDS, and others with legal and employment concerns and expertise.

***"Protection of the public health was acknowledged as the highest priority of the Task Force."***

On October 1, 1985, the AIDS Task Force held its first meeting. Subsequent meetings were held at monthly intervals until August, 1986, when Report #1 of the Georgia Task Force on AIDS was published by the Department of Human Resources. The initial Report and Recommendations, which are summarized in this article, were adopted unanimously by the Task Force after intense discussions of the available data and their implications. All of

Dr. Skelton is Chairman of the Georgia Task Force on AIDS. He is also Provost for Medical Affairs and Dean of the Mercer University School of Medicine. Send reprint requests to him at 1550 College St., Macon, GA 31207.

the Task Force members were acutely sensitive to concerns that any actions not be viewed as either too protective of the community or of the individual.

Protection of the public health was acknowledged as the highest priority of the Task Force. However, all members agreed that there must be evidence to indicate a proposed action would provide protection before it could be endorsed. The danger of recommending actions which would be publicly popular but which would provide the public with an unrealistic perception of security was recognized. The Task Force guarded against such actions in order to focus the public on the true modes of transmission, the preventive measures which should be taken, and the policy implications of the known facts about the disease.

While never explicitly discussed, four widely held ethical principles obviously influenced the Task Force. The four are the principle of respect for persons, the harm principle, beneficence, and justice. These ethical principles are commonly applied to medicine, research, and public health. Respect for persons is generally understood. The harm principle allows restrictions on an individual's behavior in order to protect others. Beneficence requires action on behalf of the welfare of others. All require that risks be weighed against benefits. Justice requires a fair distribution of the benefits and burdens of particular actions. It also prohibits unfair discrimination, which has too often occurred as regards AIDS patients and individuals seropositive for the Human Immunodeficiency Virus (HIV).

***"Employees who are members of groups at increased risk of HIV infection or who are suspected of having AIDS should* not *be forced to undergo HIV testing."***

After studying the data which demonstrate that AIDS *is* spread by the interchange of body fluids through sexual intercourse and reception in the body of contaminated blood, and that AIDS *is not* spread by casual, person-to-person contact, the Task Force considered and made recommendations in the following areas.

A. *Workplace*

There are no reasons to exclude workers with AIDS or with evidence of HIV infection from the workplace. This recommendation was made for all work groups, although public concern has focused primarily on food handlers, health care workers, hospital admission personnel, school teachers, barbers, and beauticians. A corollary to this recommendation is that employees who are members of groups at increased risk of HIV infection or who are suspected of having AIDS should *not* be forced to undergo HIV testing. The information obtained would offer no additional protection to other workers and could subject the person to discriminatory behavior by co-workers or employees.

B. *Schools, Day Care Facilities, and Foster Care*

The greatest concern about children is that an infected child's impaired immune system may place the child at increased risk from usual childhood illnesses. While the virus is present in saliva in small concentrations, its spread has never been documented from either kissing, biting, sharing a popsicle, etc. Again, the virus is not spread by casual contact.

Thus, there is no reason to automatically exclude children with AIDS or children seropositive for HIV from school. Out of an abundance of caution it was recommended that day care or school-attendance decisions for such children be individually reached in a decision process involving the child's family, the child's physician, local school authorities, and local public health authorities.

For the HIV-infected child below age four, for certain neurologically handicapped children, and for children with oozing lesions, a more restricted (non-group) environment is advisable until more is known.

HIV screening was recommended for children at increased risk of infection who are being considered for adoption or foster care placement. It was felt potential parents should be aware of the potential medical problems of the child and the possible psychologic or social effects on their family if the child becomes ill.

C. *IV Drug Abusers*

Intravenous drug abusers are one of the major sources of spread of HIV. All intravenous drug abusers, whether in public or private treatment, should be encouraged to have their blood tested for evidence of HIV infection. All intravenous drug abusers should be educated about AIDS and

counseled to change behavior which places themselves and others at risk.

D. *Persons with Hemophilia*

Screening tests and heat treatment of factor VII concentrates have markedly reduced the risk of HIV infection for persons with hemophilia. Persons with hemophilia who show evidence of HIV infection should be treated as others in their work or school group.

***"There is a need to develop even more effective health education programs, to prescribe testing for organ donations, and to respond to new epidemiologic studies and new knowledge about the virus."***

E. *Hospitals/Medical Care Providers*

Routine administrative decisions to place any high risk group member on blood and body fluid precautions are not warranted. Decisions for blood and body fluid precautions should only be made by physicians.

F. *Funeral Homes*

Based on concerns raised by members of the funeral home industry, it was recommended that either funeral homes be notified that a person died of AIDS or had evidence of HIV infection, or that the funeral home should be notified that blood/body fluid precautions should be taken. Funeral directors were cautioned that the absence of such notification offered little protection and that the safest course was to exercise blood and body fluid precautions when dealing with any dead body.

G. *Contact Tracing*

Comprehensive contact tracing was not recommended. It was noted that in some areas of Georgia, and with some groups, the high prevalence of HIV infection would make it unlikely that contact tracing would be feasible. Contact tracing is recognized as potentially useful in low-seroprevalence areas. Also, contact tracing of HIV-positive drug abusers or bisexual males may be appropriate to locate women of childbearing age as part of a strategy to reduce the incidence of children born with AIDS.

H. *Blood Supply Safety*

There is absolutely no risk of HIV infection for people who donate blood. All needles and blood bags are prepackaged, sterile, and used only once.

Current procedures make transfusion of blood and blood products extremely unlikely to transmit the virus. The miniscule risk will be lowered even more as screening tests and alternatives to the use of blood and blood products are developed. All blood centers test each blood donation for the presence of HIV antibody, and units which are positive according to recognized screening criteria are destroyed. Anti-hemophilac factor is now heat treated prior to use. This, plus screening of donors, makes infection with the virus highly improbable. Nonetheless, cases of AIDS will continue to occur in people who received transfusions or anti-hemophilac factor before the implementation of current safety measures.

I. *Sperm Donors*

The Department of Human Resources should adopt rules and regulations mandating the testing of sperm donors for antibodies to HIV.

***"Contact tracing of HIV-positive drug abusers or bisexual males may be appropriate to locate women of childbearing age as part of a strategy to reduce the incidence of children born with AIDS."***

J. *Bathhouses*

Bathhouses which allow sexual activities were recognized as contributing to the spread of HIV. Legislation to accomplish the closing of such bathhouses was passed by the 1986 General Assembly and signed by Governor Harris.

K. *Prostitution*

It was recommended that convicted prostitutes be tested for HIV and that all prostitutes receive health education regarding AIDS, especially its mode of transmission and methods to prevent transmission.

L. *Perinatal AIDS*

The recommendations of the Centers for Disease Control were reviewed and endorsed. This includes the offering of counseling and testing for HIV to pregnant women and women of childbearing age in the following groups: (1) those with evidence of HIV infection; (2) those who have engaged in the abuse of drugs by intravenous injection; (3) those born in countries where heterosexual transmission of the virus plays a major role; (4) those who have engaged in prostitution; (5) sex partners of: IV drug abusers, bisexual men, men with hemophilia, men born in countries where heterosexual transmission plays a major role, or men with evidence of HIV infection.

The Department of Human Resources should adopt regulations to decrease the incidence of perinatal AIDS by encouraging at risk women to seek counseling and HIV testing. These regulations are now being considered by the Board of Human Resources.

***"It is important in addressing all of these matters that the process of review and consideration be a highly public one involving highly qualified professionals and other concerned citizens of Georgia. Only in this way can fact overcome fear and the activity created by the AIDS problems be channeled into constructive action."***

M. *Health Education*

Health education is the principal means available at this time to reduce spread of HIV. The establishment of an ongoing comprehensive health education program was urged on the Department of Human Resources. With support of state leaders, the Department of Human Resources has developed major health education programs. The support of the federal government has been critical to this effort. Coordination between the Department of Human Resources and AID Atlanta, an organization devoted to providing and/or obtaining care for AIDS victims and to preventing the spread of AIDS, has been of major importance in providing high quality educational services.

The incidence of AIDS and the population of persons infected with HIV will continue to increase. Educational efforts and blood and blood products testing have reduced the risk of exposure, and future cases will develop at a slower rate. Nonetheless, the absolute number of cases and the inadequacy of current health and social systems will result in continued public interest and concern.

The Georgia Task Force on AIDS will continue to consider all of the problems related to AIDS and to HIV infection. There is a need to develop even more effective health education programs, to prescribe testing for organ donations, and to respond to new epidemiologic studies and new knowledge about the virus. As some methods of treatment for AIDS become available, there will be a need to reconsider contact tracing and other approaches to facilitate early identification and treatment. And, most importantly, is the need to develop a long-term plan to respond to the health and social service demands and implications of HIV infection.

It is important in addressing all of these matters that the process of review and consideration be a highly public one involving highly qualified professionals and other concerned citizens of Georgia. Only in this way can fact overcome fear and the activity created by the AIDS problems be channeled into constructive action.

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*(Editorial Note: The Public Health Committee of the Medical Association of Georgia is assuming a very active role in communicating to physicians accurate and balanced information on the prevention, diagnosis, and treatment of AIDS. The Committee supports the activities of the Georgia Task Force on AIDS and is presently developing, in cooperation with the DHR AIDS Health Education office, a physicians training program. The Association is presently a co-sponsor to the International Conference on AIDS and will host a physician regional training workshop with the American Medical Association in March, 1987.)*

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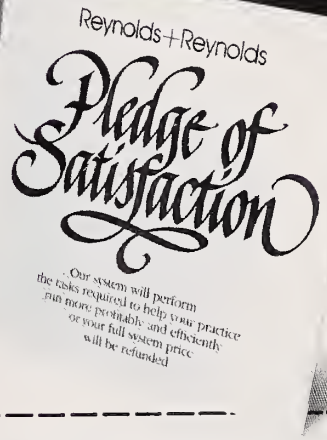


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# Surgeon General's Report on Acquired Immune Deficiency Syndrome

## AIDS

### AIDS Caused by Virus

The letters A-I-D-S stand for Acquired Immune Deficiency Syndrome. When a person is sick with AIDS, he/she is in the final stages of a series of health problems caused by a virus (germ) that can be passed from one person to another chiefly during sexual contact or through the sharing of intravenous drug needles and syringes used for "shooting" drugs. Scientists have named the AIDS virus "HIV or HTLV-III or LAV."[1] These abbreviations stand for information denoting a virus that attacks white blood cells (T-Lymphocytes) in the human blood. Throughout this publication, we will call the virus the "AIDS virus." The AIDS virus attacks a person's immune system and damages his/her ability to fight other disease. Without a functioning immune system to ward off other germs, he/she now becomes vulnerable to becoming infected by bacteria, protozoa, fungi, and other viruses and malignancies, which may cause life-threatening illness, such as pneumonia, meningitis, and cancer.

### No Known Cure

There is presently no cure for AIDS. There is presently no vaccine to prevent AIDS.

### Virus Invades Blood Stream

When the AIDS virus enters the blood stream, it begins to attack certain white blood cells (T-Lymphocytes). Substances called antibodies are produced by the body. These antibodies can be detected in the blood by a simple test, usually two weeks to three months after infection. Even before the antibody test is positive, the victim can pass the virus to others by methods that will be explained.

Once an individual is infected, there are several possibilities. Some people may remain well but even so they are able to infect others. Others may develop a disease that is less serious than AIDS referred to as AIDS Related Complex (ARC). In some people the protective immune system may be destroyed by the virus and then other germs (bacteria, protozoa, fungi, and other viruses) and cancers that ordinarily would never get a foothold cause "opportunistic diseases . . ." using the *opportunity* of lowered resistance to infect and destroy. Some of the most common are *Pneumocystis carinii* pneumonia and tuberculosis. Individuals infected with the AIDS virus may also develop certain types of cancers such as Kaposi's sarcoma. These infected people have classic AIDS. Evidence shows that the AIDS virus may also attack the nervous system, causing damage to the brain.

## SIGNS AND SYMPTOMS

### No Signs

Some people remain apparently well after infection with the AIDS virus. They may have no physically apparent symptoms of illness. However, if proper precautions are not used with sexual contacts and/or intravenous drug use, these infected individuals can spread the virus to others. Anyone who thinks he or she is infected or involved in high risk behaviors should not donate his/her blood, organs, tissues, or sperm because they may now contain the AIDS virus.

## ARC

AIDS-Related Complex (ARC) is a condition caused by the AIDS virus in which the patient tests positive for AIDS infection and has a specific set of clinical symptoms. However, ARC patients' symptoms are often less severe than those with the disease we call classic AIDS. Signs and symptoms of ARC may include loss of appetite, weight loss, fever, night sweats, skin rashes, diarrhea, tiredness, lack of resistence to infection, or swollen lymph nodes. These are also signs and symptoms of many other diseases and a physician should be consulted.

## AIDS

Only a qualified health professional can diagnose AIDS, which is the result of a natural progress of infection by the AIDS virus. AIDS destroys the body's immune (defense) system and allows otherwise controllable infections to invade the body and cause additional diseases. These opportunistic diseases would not otherwise gain a foothold in the body. These opportunistic diseases may eventually cause death.

Some symptoms and signs of AIDS and the "opportunistic infections" may include a persistent cough and fever associated with shortness of breath or difficult breathing and maybe the symptoms of *Pneumocystis carinii* pneumonia. Multiple purplish blotches and bumps on the skin may be a sign of Kaposi's sarcoma. The AIDS virus in all infected people is essentially the same; the reactions of individuals may differ.

### Long Term

The AIDS virus may also attack the nervous system and cause delayed damage to the brain. This damage may take years to develop and the symptoms may show up as memory loss.

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[1] These are different names given to AIDS virus by the scientific community:
HIV — Human Immunodeficiency Virus
HTLV-III — Human T-Lymphotropic Virus Type III
LAV — Lymphadenopathy Associated Virus

indifference, loss of coordination, partial paralysis, or mental disorder. These symptoms may occur alone, or with other symptoms mentioned earlier.

## AIDS: THE PRESENT SITUATION

The number of people estimated to be infected with the AIDS virus in the United States is about 1.5 million. All of these individuals are assumed to be capable of spreading the virus sexually (heterosexually or homosexually) or by sharing needles and syringes or other implements for intravenous drug use. Of these, an estimated 100,000 to 200,000 will come down with AIDS-Related Complex (ARC). It is difficult to predict the number who will develop ARC or AIDS because symptoms sometimes take as long as nine years to show up. With our present knowledge, scientists predict that 20 to 30 percent of those infected with the AIDS virus will develop an illness that fits an accepted definition of AIDS within five years. The number of persons known to have AIDS in the United States to date is over 25,000; of these, about half have died of the disease. Since there is no cure, the others are expected to also eventually die from their disease.

The majority of infected antibody positive individuals who carry the AIDS virus show no disease symptoms and may not come down with the disease for many years, if ever.

### No Risk from Casual Contact

There is no known risk of non-sexual infection in most of the situations we encounter in our daily lives. We know that family members living with individuals who have the AIDS virus do not become infected except through sexual contact. There is no evidence of transmission (spread) of AIDS virus by everyday contact even though these family members share food, towels, cups, razors, even toothbrushes and kissed each other.

### Health Workers

We know even more about health care workers exposed to AIDS patients. About 2500 health workers who were caring for AIDS patients when they were sickest have been carefully studied and tested for infection with the AIDS virus. These doctors, nurses and other health care givers have been exposed to the AIDS patients' blood, stool and other body fluids. Approximately 750 of these health workers reported possible additional exposure by direct contact with a patient's body fluid through spills or being accidentally stuck with a needle. Upon testing these 750, only 3 who had accidentally stuck themselves with a needle had a positive antibody test for exposure to the AIDS virus. Because health workers had much more contact with patients and their body fluids than would be expected from common everyday contact, it is clear that the AIDS virus is not transmitted by casual contact.

### Control of Certain Behaviors Can Stop Further Spread of AIDS

Knowing the facts about AIDS can prevent the spread of the disease. Education of those who risk infecting themselves or infecting other people is the only way we can stop the spread of AIDS. People must be responsible about their sexual behavior and must avoid the use of illicit intravenous drugs and needle sharing. We will describe the types of behavior that lead to infection by the AIDS virus and the personal measures that must be taken for effective protection. If we are to stop the AIDS epidemic, we all must understand the disease — its cause, its nature, and its prevention. *Precautions must be taken.* The AIDS virus infects persons who expose themselves to known risk behavior, such as certain types of homosexual and heterosexual activities or sharing intravenous drug equipment.

### Risks

Although the initial discovery was in the homosexual community, AIDS is not a disease only of homosexuals. AIDS is found in heterosexual people as well. AIDS is not a black or white disease. AIDS is not just a male disease. AIDS is found in women; it is found in children. In the future AIDS will probably increase and spread among people who are not homosexual or intravenous drug abusers in the same manner as other sexually transmitted diseases like syphilis and gonorrhea.

### Sex Between Men

Men who have sexual relations with other men are especially at risk. About 70 percent of AIDS victims throughout the country are male homosexuals and bisexuals. This percentage probably will decline as heterosexual transmission increases. *Infection results from a sexual relationship with an infected person.*

### Multiple Partners

The risk of infection increased according to the number of sexual partners one has, *male or female.* The more partners you have, the greater the risk of becoming infected with the AIDS virus.

### How Exposed

Although the AIDS virus is found in several body fluids, a person acquires the virus during sexual contact with an infected person's blood or semen and possibly vaginal secretions. The virus then enters a person's blood stream through their rectum, vagina or penis.

Small (unseen by the naked eye) tears in the surface lining of the vagina or rectum may occur during insertion of the penis, fingers, or other objects, thus opening an avenue for entrance of the virus directly into the blood stream; therefore, the AIDS virus can be passed from penis to rectum and vagina and vice versa without a visible tear in the tissue or the presence of blood.

### Prevention of Sexual Transmission — Know Your Partner

Couples who maintain mutually faithful monogamous relationships (only one continuing sexual partner) are protected from AIDS through sexual transmission. If you have been faithful for at least five years and your partner has been faithful too, neither of you is at risk. If you have not been faithful, then you and your partner are at risk. If your partner has not been faithful, then your partner is at risk which also puts you at risk. This is true for both heterosexual and homosexual couples. Unless it is possible to know with *absolute certainty* that neither you nor your sexual partner is not carrying the virus of AIDS, you must use protective behavior. *Abso-*

*lute certainty* means not only that you and your partner have maintained a mutually faithfully monogamous sexual relationship, but it means that neither you nor your partner has used illegal intravenous drugs.

## AIDS: YOU CAN PROTECT YOURSELF FROM INFECTION

Some personal measures are adequate to safely protect your self and others from infection by the AIDS virus and its complications. Among these are:

- If you have been involved in any of the high risk sexual activities described above or have injected illicit intravenous drugs into your body, you should have a blood test to see if you have been infected with the AIDS virus.
- If your test is positive or if you engage in high risk activities and choose not to have a test, you should tell your sexual partner. If you jointly decide to have sex, you must protect your partner by always using a rubber (condom) during (start to finish) sexual intercourse (vagina or rectum).
- If your partner has a positive blood test showing that he/she has been infected with the AIDS virus or you suspect that he/she has been exposed by previous heterosexual or homosexual behavior or use of intravenous drugs with shared needles and syringes, a rubber (condom) should always be used during (start to finish) sexual intercourse (vagina or rectum).
- If you or your partner is at high risk, avoid mouth contact with the penis, vagina, or rectum.
- Avoid all sexual activities which could cause cut or tears in the linings of the rectum, vagina, or penis.
- Single teen-age girls have been warned that pregnancy and contracting sexually transmitted diseases can be the result of only one act of sexual intercourse. They have been taught to say *NO* to sex! They have been taught to say *NO* to drugs! By saying *NO* to sex and drugs, they can avoid AIDS which can kill them! The same is true for teen-age boys who should also not have rectal intercourse with other males. It may result in AIDS.
- Do not have sex with prostitutes. Infected male and female prostitutes are frequently also intravenous drug abusers; therefore, they may infect clients by sexual intercourse and other intravenous drug abusers by sharing their intravenous drug equipment. Female prostitutes also can infect their unborn babies.

### Intravenous Drug Users

Drug abusers who inject drugs into their veins are another population group at high risk and with high rates of infection by the AIDS virus. Users of intravenous drugs make up 25 percent of the cases of AIDS throughout the country. The AIDS virus is carried in contaminated blood left in the needle, syringe, or other drug related implements and the virus is injected into the new victim by reusing dirty syringes and needles. Even the smallest amount of infected blood left in a used needle or syringe can contain live AIDS virus to be passed on to the next user of those dirty implements.

No one should shoot up drugs because of addiction, poor health, family disruption, emotional disturbances and death that follow. However, many drug users are addicted to drugs and for one reason or another have not changed their behavior. For these people, the only way not to get AIDS is *to use a clean, previously unused* needle, syringe or any other implement necessary for the injection of the drug solution.

### Hemophilia

Some persons with hemophilia (a blood clotting disorder that makes them subject to bleeding) have been infected with the AIDS virus either through blood transfusion or the use of blood products that help their blood clot. Now that we know how to prepare safe blood products to aid clotting, this is unlikely to happen. This group represents a very small percentage of the cases of AIDS throughout the country.

### Blood Transfusion

Currently all blood donors are initially screened and blood is *not* accepted from high risk individuals. Blood that has been collected for use is tested for the presence of antibody to the AIDS virus. However, some people may have had a blood transfusion prior to March 1985 before we knew how to screen blood for safe transfusion and may have become infected with the AIDS virus. Fortunately there are not now a large number of these cases. With routine testing of blood products, the blood supply for transfusions is now safer than it has ever been with regard to AIDS.

Persons who have engaged in homosexual activities or have shot street drugs within the last 10 years should *never* donate blood.

### Mother Can Infect Newborn

If a woman is infected with the AIDS virus and becomes pregnant, she is more likely to develop ARC or classic AIDS, and she can pass the AIDS virus to her unborn child. Approximately one-third of the babies born to AIDS-infected mothers will also be infected with the AIDS virus. Most of the infected babies will eventually develop the disease and die. Several of these babies have been born to wives of hemophiliac men infected with the AIDS virus by way of contaminated blood products. Some babies have also been born to women who have become infected with the AIDS by bisexual partners who had the virus. Almost all babies born with AIDS have been born to women who were intravenous drug users or the sexual partners of intravenous drug users who were infected with the AIDS virus. More such babies can be expected.

Think carefully if you plan on becoming pregnant. If there is any chance that you may be in any high risk group or that you have had sex with someone in a high risk group, such as homosexual and bisexual males, drug abusers and their sexual partners, see your doctor.

### Summary

*AIDS affects certain groups of the population. Homosexual and bisexual males who have had sexual contact with other homosexual or bisexual males as well as those who "shoot" street drugs are at greatest risk of exposure, infection and eventual death. Sexual partners of these high risk individuals are at risk; as well as any children born to women*

*who carry the virus. Heterosexual persons are increasingly at risk.*

## AIDS: WHAT IS SAFE

### Most Behavior Is Safe

Everyday living does not present any risk of infection. You *cannot* get AIDS from casual social contact. Casual social contact should not be confused with casual *sexual* contact which is a major cause of the spread of the AIDS virus. Casual *social* contact such as shaking hands, hugging, social kissing, crying, coughing or sneezing, will not transmit the AIDS virus. Nor has AIDS been contracted from swimming in pools or hot tubs or from eating in restaurants (even if a restaurant worker has AIDS or carries the AIDS virus). AIDS is not contracted from sharing bed linens, towels, cups, straws, dishes, or any other eating utensils. You cannot get AIDS from toilets, doorknobs, telephones, office machinery, or household furniture. You cannot get AIDS from body massages, masturbation or any non-sexual body contact.

### Donating Blood

Donating blood is *not* risky at all. *You cannot get AIDS by donating blood.*

### Receiving Blood

In the US every blood donor is screened to exclude high risk persons and every blood donation is now tested for the presence of antibodies to the AIDS virus. Blood that shows exposure to the AIDS virus by the presence of antibodies is not used either for transfusion or for the manufacture of blood products. Blood banks are as safe as current technology can make them. Because antibodies do not form immediately after exposure to the virus, a newly infected person may unknowingly donate blood after becoming infected but before his/her antibody test becomes positive. It is estimated that this might occur less than once in 100,000 transfusions.

There is no danger of AIDS virus infection from visiting a doctor, dentist, hospital, hairdresser or beautician. AIDS cannot be transmitted non-sexually from an infected person through a health or service provider to another person. Ordinary methods of disinfection for urine, stool and vomitus which are used for non-infected people are adequate for people who have AIDS or are carrying the AIDS virus. You may have wondered why your dentist wears gloves and perhaps a mask when treating you. This does not mean that he has AIDS or that he thinks you do. He is protecting you and himself from hepatitis, common colds or flu.

There is no danger in visiting a patient with AIDS or caring for him or her. Normal hygienic practices, like wiping of body fluid spills with a solution of water and household bleach (1 part household bleach to 10 parts water), will provide full protection.

### Children in School

None of the identified cases of AIDS in the United States are known or are suspected to have been transmitted from one child to another in school, day care, or foster care settings. Transmission would necessitate exposure of open cuts to the blood or other body fluids of the infected child, a highly unlikely occurrence. Even then routine safety procedures for handling blood or other body fluids (which should be standard for all children in the school or the day care setting) would be effective in preventing transmission from children with AIDS to other children in school.

Children with AIDS are highly susceptible to infections, such as chicken pox, from other children. Each child with AIDS should be examined by a doctor before attending school or before returning to school, day care or foster care settings after an illness. No blanket rules can be made for all schoolboards to cover all possible cases of children with AIDS and each case should be considered separately and individualized to the child and the setting, as would be done with any child with a special problem, such as cerebral palsy or asthma. A good team to make such decisions with the schoolboard would be the child's parents, physician and a public health official.

Casual social contact between children and persons infected with the AIDS virus is not dangerous.

### Insects

There are no known cases of AIDS transmission by insects, such as mosquitoes.

### Pets

Dogs, cats and domestic animals are not a source of infection from AIDS virus.

### Tears and Saliva

Although the AIDS virus has been found in tears and saliva, no instance of transmission from these body fluids has been reported.

*AIDS comes from sexual contacts with infected persons and from the body sharing of syringes and needles. There is no danger of infection with AIDS virus by casual social contact.*

### Testing of Military Personnel

You may wonder why the Department of Defense is currently testing its uniformed services personnel for presence of the AIDS virus antibody. The military feel this procedure is necessary because the uniformed services act as their own blood bank in a time of national emergency. They also need to protect new recruits (who unknowingly may be AIDS virus carriers) from receiving live virus vaccines. These vaccines could activate disease and be potentially life-threatening to the recruits.

## AIDS: WHAT IS CURRENTLY UNDERSTOOD

Although AIDS is still a mysterious disease in many ways, our scientists have learned a great deal about it. In five years we know more about AIDS than many diseases that we have studied for even longer periods. While there is no vaccine or cure, the results from the health and behavioral research community can only add to our knowledge and increase our understanding of the disease and ways to prevent and treat it.

In spite of all that is known about transmission of the AIDS virus, scientists will learn more. One possibility is the potential discovery of factors that may better explain the mechanism of AIDS infection.

### Why are the antibodies produced by the body to fight the AIDS virus not able to destroy that virus?

The antibodies detected in the blood of carriers of the AIDS virus are ineffective, at least when classic AIDS is actually triggered. They cannot

check the damage caused by the virus, which is by then present in large numbers in the body. Researchers cannot explain this important observation. We still do not know why the AIDS virus is not destroyed by man's immune system.

### Summary

AIDS no longer is the concern of any one segment of society; it is the concern of us all. No American's life is in danger if he/she or their sexual partners do not engage in high risk sexual behavior or use shared needles or syringes to inject illicit drugs into the body.

People who engage in high risk sexual behavior or who shoot drugs are risking infection with the AIDS virus and are risking their lives and the lives of others, including their unborn children.

We cannot yet know the full impact of AIDS on our society. From a clinical point of view, there may be new manifestations of AIDS — for example, mental disturbances due to the infection of the brain by the AIDS virus in carriers of the virus. From a social point of view, it may bring to an end the free-wheeling sexual lifestyle which has been called the sexual revolution. Economically, the care of AIDS patients will put a tremendous strain on our already overburdened and costly health care delivery system.

The most certain way to avoid getting the AIDS virus and to control the AIDS epidemic in the United States is for individuals to avoid promiscuous sexual practices, to maintain mutually faithful monogamous sexual relationships and to avoid injecting illicit drugs.

## LOOK TO THE FUTURE

### The Challenge of the Future

An enormous challenge to public health lies ahead of us and we would do well to take a look at the future. We must be prepared to manage those things we can predict, as well as those we cannot.

At the present time there is no vaccine to prevent AIDS. There is no cure. AIDS, which can be transmitted sexually and by sharing needles and syringes among illicit intravenous drug users, is bound to produce profound changes in our society, changes that will affect us all.

### Information and Education Only Weapons Against AIDS

It is estimated that in 1991 54,000 people will die from AIDS. At this moment, many of them are not infected with the AIDS virus. With proper information and education, as many as 12,000 to 14,000 people could be saved in 1991 from death by AIDS.

### AIDS Will Impact All

The changes in our society will be economic and political and will affect our social institutions, our educational practices, and our health care. Although AIDS may never touch you personally, the social impact certainly will.

### Be Educated — Be Prepared

Be prepared. Learn as much about AIDS as you can. Learn to separate scientific information from rumor and myth. The Public Health Service, your local public health officials and family physician will be able to help you.

### Concern About Spread of AIDS

While the concentration of AIDS cases is in the larger urban areas today, it has been found in every state and with the mobility of our society, it is likely that cases of AIDS will appear far and wide.

### Special Educational Concerns

There are a number of people, primarily adolescents, that do no yet know they will be homosexual or become drug abusers and will not heed this message; there are others who are illiterate and cannot heed this message. They must be reached and taught the risk behaviors that expose them to infection with the AIDS virus.

### High Risk Get Blood Test

The greatest public health problem lies in the large number of individuals with a history of high risk behavior who have been infected with and may be spreading the AIDS virus. Those with high risk behavior must be encouraged to protect others by adopting safe sexual practices and by the use of clean equipment for intravenous drug use. If a blood test for antibodies to the AIDS virus is necessary to get these individuals to use safe sexual practices, they should get a blood test. Call your local health department for information on where to get the test.

### Anger and Guilt

Some people afflicted with AIDS will feel a sense of anger and others a sense of guilt. In spite of these understandable reactions, everyone must join the effort to control the epidemic, to provide for the care of those with AIDS, and to do all we can to inform and educate others about AIDS, and how to prevent it.

### Confidentiality

Because of the stigma that has been associated with AIDS, many afflicted with the disease or who are infected with the AIDS virus are reluctant to be identified with AIDS. Because there is no vaccine to prevent AIDS and no cure, many feel there is nothing to be gained by revealing sexual contacts that might also be infected with the AIDS virus. When a community or state requires reporting of those infected with the AIDS virus to public health authorities in order to trace sexual and intravenous drug contacts — as is the practice with other sexually transmitted diseases — those infected with the AIDS virus have gone underground out of the mainstream of health care and education. For this reason current public health practice is to protect the privacy of the individual infected with the AIDS virus and to maintain the strictest confidentiality concerning his/her health records.

### State and Local AIDS Task Forces

Many state and local jurisdictions where AIDS has been seen in the greatest numbers have AIDS task forces with heavy representation from the field of public health joined by others who can speak broadly to issues of access to care, provision of care and the availability of community and psychiatric support services. Such a task force is needed in every community with the power to develop plans and policies, to speak, and to act for the good of the public health at every level.

State and local task forces should plan ahead and work collaboratively with other jurisdictions to reduce transmission of AIDS by far-reaching informational and educational programs. As AIDS impacts more strongly on society, they should be charged with making recommendations to provide for the needs of those afflicted with AIDS. They also will be in the best position to answer the concerns and direct the activities of those who are not infected with the AIDS virus.

The responsibility of state and local task forces should be far reaching and might include the following areas:

- Insure enforcement of public health regulation of such practices as ear piercing and tattooing to prevent transmission of AIDS virus.
- Conduct AIDS educational programs for police, firemen, correctional institution workers and emergency medical personnel for dealing with AIDS victims and the public.
- Insure that institutions catering to children or adults who soil themselves or their surroundings with urine, stool, and vomitus have adequate equipment for cleanup and disposal, and have policies to insure the practice of good hygiene.

### School

Schools will have special problems in the future. In addition to the guidelines already mentioned in this pamphlet, there are other things that should be considered such as sex education and education of the handicapped.

### Sex Education

Education concerning AIDS must start at the lowest grade possible as part of any health and hygiene program. The appearance of AIDS could bring together diverse groups of parents and educators with opposing views on inclusion of sex education in the curricula. There is now no doubt that we need sex education in schools and that it include information on heterosexual and homosexual relationships. The threat of AIDS should be sufficient to permit a sex education curriculum with a heavy emphasis on prevention of AIDS and other sexually transmitted diseases.

### Handicapped and Special Education

Children with AIDS or ARC will be attending school along with others who carry the AIDS virus. Some children will develop brain disease which will produce changes in mental behavior. Because of the right to special education of the handicapped and the mentally retarded, schoolboards and higher authorities will have to provide guidelines for the management of such children on a case-by-case basis.

### Labor and Management

Labor and management can do much to prepare for AIDS so that misinformation is kept to a minimum. Unions should issue preventive health messages because many employees will listen more carefully to a union message than they will to one from public health authorities.

### AIDS Education at the Work Site

Offices, factories, and other work sites should have a plan in operation for education of the work force and accommodation of AIDS or ARC patients *before* the first such case appears at the work site. Employees with AIDS or ARC should be dealt with as are any workers with a chronic illness. In-house video programs provide an excellent source of education and can be individualized to the needs of a specific work group.

### Strain on the Health Care Delivery System

The health care system in many places will be overburdened as it is now in urban areas with large numbers of AIDS patients. It is predicted that during 1991 there will be 145,000 patients requiring hospitalization at least once and 54,000 patients who will die of AIDS. Mental disease (dementia) will occur in some patients who have the AIDS virus before they have any other manifestation such as ARC or classic AIDS.

State and local task forces will have to plan for these patients by utilizing conventional and time honored systems but will also have to investigate alternate methods of treatment and alternative sites for care including home-care.

The strain on the health system can be lessened by family, social, and psychological support mechanisms in the community. Programs are needed to train chaplains, clergy, social workers, and volunteers to deal with AIDS. Such support is critical to the minority communities.

### Mental Health

Our society will also face an additional burden as we better understand the mental health implications of infection by the AIDS virus. Upon being informed of infection with the AIDS virus, a young, active, vigorous person faces anxiety and depression brought on by fears associated with social isolation, illness, and dying. Dealing with these individual and family concerns will require the best efforts of mental health professionals.

### Controversial Issues

A number of controversial AIDS issues have arisen and will continue to be debated largely because of lack of knowledge about AIDS, how it is spread, and how it can be prevented. Among these are the issues of compulsory blood testing, quarantine, and identification of AIDS carriers by some visible sign.

### Compulsory Blood Testing

Compulsory blood testing of individuals is not necessary. The procedure could be unmanageable and cost prohibitive. It can be expected that many who *test* negatively might actually be positive due to *recent* exposure to the AIDS virus and give a false sense of security to the individual and his/her sexual partners concerning necessary protective behavior. The prevention behavior described in this report, if adopted, will protect the American public and contain the AIDS epidemic. Voluntary testing will be available to those who have been involved in high risk behavior.

### Quarantine

Quarantine has no role in the management of AIDS because AIDS is not spread by casual contact. The only time that some form of quarantine might be indicated is in a situation where an individual carrying the AIDS virus knowingly and willingly continues to expose others through sexual contact or sharing drug equipment. Such circumstances should be man-

aged on a case-by-case basis by local authorities.

### Identification of AIDS Carriers by Some Visible Sign

Those who suggest the marking of carriers of the AIDS virus by some visible sign have not thought that matter through thoroughly. It would require testing of the entire population which is unnecessary, unmanageable and costly. It would miss those recently infected individuals who would test negatively, but be infected. The entire procedure would give a false sense of security. AIDS must and will be treated as a disease that can infect anyone. AIDS should not be used as an excuse to discriminate against any group or individual.

### Updating Information

As the Surgeon General, I will continually monitor the most current and accurate health, medical, and scientific information and make it available to you, the American people. Armed with this information you can join in the discussion and resolution of AIDS-related issues that are critical to your health, your children's health, and the health of the nation.

THIS SPACE CONTRIBUTED AS A PUBLIC SERVICE

To understand much of what we're doing with respect to cancer research, you'd need a graduate degree in microbiology or biochemistry.

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## ADDITIONAL INFORMATION

### Telephone Hotlines (Toll Free)

PHS AIDS Hotline
800-342-AIDS
800-342-2437

Nationally Sexually Transmitted Diseases Hotline/American Social Health Association
800-227-8922

National Gay Task Force AIDS Information Hotline
800-221-7044
(212) 807-6016 (NY State)

### Information Sources

*U.S. Public Health Service Public Affairs Office*
Hubert H. Humphrey Building
Room 721-H
200 Independence Avenue, SW
Washington, DC 20201
Phone: (202) 245-6867

*Local Red Cross or American Red Cross AIDS Education Office*
1730 D Street, NW
Washington, DC 20006
Phone: (202) 737-8300

*American Association of Physicians for Human Rights*
PO Box 14366
San Francisco, CA 94114
Phone: (415) 558-9353

*AIDS Action Council*
729 Eighth Street, SE
Suite 200
Washington, DC 20003
Phone: (202) 547-3101

*Gay Men's Health Crisis*
PO Box 274
132 West 24th Street
New York, NY 10011
Phone: (212) 807-6655

*Hispanic AIDS Forum*
c/o APRED
853 Broadway, Suite 2007
New York, NY 10003
Phone: (212) 870-1902 or 870-1864

*Los Angeles AIDS Project*
1362 Santa Monica Boulevard
Los Angeles, CA 90046
Phone: (213) 871-AIDS

*Minority Task Force on AIDS*
c/o New York City Council of Churches
475 Riverside Drive, Room 456
New York, NY 10115
Phone: (212) 749-1214

*Mothers of AIDS Patients (MAP)*
c/o Barbara Peabody
3403 E Street
San Diego, CA 92102
Phone: (619) 234-3432

*National AIDS Network*
729 Eighth Street, SE, Suite 300
Washington, DC 20003
Phone: (202) 546-2424

*National Association of People with AIDS*
PO Box 65472
Washington, DC 20035
Phone: (202) 483-7979

*National Coalition of Gay Sexually Transmitted Disease Services*
c/o Mark Behar
PO Box 239
Milwaukee, WI 53201
Phone: (414) 277-7671

*National Council of Churches/AIDS Task Force*
475 Riverside Drive, Room 572
New York, NY 10115
Phone: (212) 870-2421

*San Francisco AIDS Foundation*
333 Valencia Street, 4th Floor
San Francisco, CA 94103
Phone: (415) 863-2437

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# International Conference on

# AIDS IN CHILDREN, ADOLESCENTS AND HETEROSEXUAL ADULTS:

# An Interdisciplinary Approach to Prevention

SPONSORED BY:

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**Emory University School of Medicine**
**Georgia Department of Human Resources**
**International Society for Sexually Transmitted Disease Research**
**Medical Association of Atlanta**
**Medical Association of Georgia**
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**and other national and international organizations**

The Westin Peachtree Plaza Hotel
Atlanta, Georgia, U.S.A.

**THURSDAY, FEBRUARY 19 THROUGH SATURDAY, FEBRUARY 21, 1987**

■ N O R T H A M E R I C A ■ A S I A ■
ANTIVIRALS ■ ANTIBODIES ■ PUBLIC HEALTH ■ EDUCATION ■ CHILDREN ■ LEGISLATION ■ NURSING ■

## PURPOSE

The first wave of the AIDS epidemic was recognized in Western countries in 1981 among homosexual men. Within the following two years, the second wave related to blood (hemophiliacs, blood transfusion recipients, and intravenous drug users) became apparent. Hidden since the beginning and rapidly increasing in numbers, particularly in Central Africa, Haiti and New York City, is the impact of this infection in women and children. This growing third wave of the epidemic of AIDS must be stopped by preventing the birth of infected babies and by educating children and adolescents to avoid becoming infected themselves and heterosexually transmitting the virus eventually to their own offspring. Only with the interaction of many disciplines among scientists and health care workers, educators, sociologists, psychologists, legal experts, communicators, and others can this difficult challenge be confronted intelligently.

The purpose of this conference then is to bring together such interested individuals from diverse areas to learn, to share information, and to arrive at practical and realistic approaches to the prevention of HIV infection and AIDS in babies, children and older individuals.

## FORMAT

The program comprises:

- Overviews by experts from different disciplines to update information on particular subjects
- Poster sessions to present the most recent data, as well as provide educational information on topics related to AIDS
- Round table discussions on various acute problems to provide dialogue between the various disciplines represented at this conference
- Workshops for the separate disciplines to assemble and define practical and realistic approaches to the prevention of HIV infection

## INTERNATIONAL ORGANIZING COMMITTEE

James Alley, USA
Dewitt Baldwin, Jr., USA
George Brumley, USA
Nathan Clumeck, Belgium
Frank Eldridge, USA
Roger Henrion, France
Jean Hutton, UK
Sidney Kibrick, USA
Jonathan Mann, Switzerland
Jacqueline Muther, USA *(Coordinator)*
André Nahmias, USA *(Chairman)*
Rafael Najera, Spain
James Oleske, USA
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Eric Sandstrom, Sweden
Raymond Schinazi, USA
Gwendolyn Scott, USA
Paul Wehrle, USA
Richard Whitley, USA
Fernando Zacarias, Mexico

## CONFERENCE ADDRESS

I.I.A.F. Conference
Pediatrics (Emory)
69 Butler Street, S.E.
Atlanta, Georgia 30303 USA
Telephone: (404) 589-4997

## REGISTRATION FORM — For Use By Medical Association of Georgia Members Only

*Complete and return to:*

**I.I.A.F. CONFERENCE,** Pediatrics (Emory), 69 Butler Street, S.E., Atlanta, Georgia 30303

LAST NAME (SURNAME) _____ FIRST _____ MIDDLE _____

TITLE _____ DEPARTMENT _____

INSTITUTION OR ORGANIZATION _____ ADDRESS _____

CITY _____ STATE/ZIP CODE _____ COUNTRY _____

PHONE (INCLUDING AREA CODE): OFFICE _____ HOME _____

AREA OF MAJOR INTEREST: _____

**PLEASE CHECK DESIRED REGISTRATION PACKAGE (Registration is limited)**

_____ A. $275.00: Full registration for all three days (includes lunches, banquet and published proceedings of the meeting)

_____ B. $225.00: Full registration for all three days (includes lunches only)

Or choose one or more of the following blocks (include lunch only):

_____ C. $150.00: 8:30 AM Thursday, Feb. 19 through 10:00 PM Friday, Feb. 20

_____ D. $150.00: 8:00 PM Thursday, Feb. 19 through 5:30 PM Saturday, Feb. 21

_____ E. $ 75.00: 8:30 AM through 10:00 PM Thursday, Feb. 19

_____ F. $ 75.00: 8:00 PM Thursday, Feb. 19 through 10:00 PM Friday, Feb. 20

_____ G. $ 75.00: 8:00 PM Friday, Feb. 20 through 5:30 PM Saturday, Feb. 21

Do you also wish to attend the banquet on Saturday, Feb. 21?
(Must be registered for at least one day of conference)

_____ H. $ 35.00: Banquet

_____ I. $ 35.00: Banquet for spouse

_____ **TOTAL ENCLOSED** (Make check payable to IIAF CONFERENCE)

**WORKSHOP SELECTION:**

(Three workshops will run concurrently on each day. Please indicate your first choice with a "1" and your second choice with a "2" for each day you plan to attend.)

**Thursday, February 19**
CHECK ONLY ONE):

_____ A. Obstetrics and Pediatrics

_____ B. Ethical/Legal Issues

_____ C. Community-Based Services

**Friday, February 20**
(CHECK ONLY ONE):

_____ A. Educational Approaches

_____ B. Public Health Aspects

_____ C. Nursing Aspects

**HOTEL RESERVATION:** Although the deadline for registration at the Westin Peachtree Plaza is January 13, we hope to have some additional rooms available after that date at the special rate. Please indicate your preference.

_____ Single Room ($69/day + 8% tax — to be paid at time of meeting)

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Anticipated Arrival: **Date** _____ **Time** _____ Anticipated Departure: **Date** _____ **Time** _____

**WEDNESDAY, FEBRUARY 18**

| | |
|---|---|
| 6:00 — 9:00 PM | REGISTRATION AND WELCOME |

**THURSDAY, FEBRUARY 19 — THE HETEROSEXUAL ADULT**

| | |
|---|---|
| 7:30 AM | REGISTRATION* |
| **8:30 AM — 12:00 PM** | **PLENARY SESSIONS** |
| | OVERVIEWS: |
| | **The Virus and Its Identification** |
| | **Heterosexual Transmission of the Virus** |
| | **Impact and Management of the Infection in Women** |
| 10:00 AM — 10:30 AM | COFFEE BREAK* |
| | **Legal/Judicial Issues:**<br>In the U.S.<br>In the World |
| | **Role of the Media: information and education** |
| 12:00 PM — 1:30 PM | LUNCH* |
| **1:30 PM — 5:30 PM** | **PLENARY SESSIONS** |
| | ACUTE PROBLEM ROUND TABLES: |
| | **Strategies in the Control of the Heterosexual Infected Pool** |
| 3:15 PM — 3:45 PM | COFFEE BREAK* |
| | **Strategies in the Identification and Control of the Infected Pregnant Woman** |
| 5:30 PM — 8:00PM | OPEN* |
| **8:00 PM — 10:00 PM** | **WORKSHOPS (Concurrent)** |
| | **A. Obstetrics and Pediatrics** |
| | **B. Ethical/Legal Issues** |
| | **C. Community-Based Services** |

**FRIDAY, FEBRUARY 20 — THE NEWBORN AND CHILD**

| | |
|---|---|
| **8:30 AM — 12:00 PM** | **PLENARY SESSIONS** |
| | OVERVIEWS: |
| | **Clinical Manifestations:**<br>General Features<br>Specific Effects on the Nervous System |
| | **Immunological Considerations:**<br>Why is the baby so much more susceptible? |
| | **The Challenge of Vaccines for AIDS** |
| | **Antiviral Drugs:**<br>Basic Approaches<br>Clinical Applications |

*POSTER SESSIONS

| | |
|---|---|
| 10:30 AM — 11:00 AM | COFFEE BREAK* |
| | **Community Resources:**<br>Financial Aspects<br>Psychological Support |
| 12:00 PM — 1:30 PM | LUNCH* |
| **1:30 PM — 5:30 PM** | **PLENARY SESSIONS** |
| | ACUTE PROBLEM ROUND TABLES: |
| | **Nosocomial Aspects** |
| 3:00 PM — 3:30 PM | COFFEE BREAK* |
| | **Adoption, Foster Care, and Day Care** |
| 5:30 PM — 8:00 PM | OPEN* |
| **8:00 PM — 10:00 PM** | **WORKSHOPS (Concurrent)** |
| | **A. Educational Approaches: Sex, Drug Abuse, Etc.** |
| | **B. Public Health Challenges** |
| | **C. Nursing Aspects** |

**SATURDAY, FEBRUARY 21 — THE ADOLESCENT**

| | |
|---|---|
| | **PLENARY SESSIONS** |
| **8:30 AM — 12:00 PM** | OVERVIEWS: |
| | **Strategies for AIDS Education and Risk Reduction** |
| | **The Sexual Struggles of the Adolescent** |
| | **Hemophiliacs: A Multidisciplined Problem** |
| | COFFEE BREAK* |
| | **Education in related areas:**<br>Sex and Family Planning<br>Sexually Transmitted Diseases<br>Substance Abuse |
| | KEYNOTE SPEAKER |
| | **"The Young as Givers"**<br>Dr. Alec Dickson |
| 12:00 PM — 1:30 PM | LUNCH* |
| **1:30 PM — 5:30 PM** | **PLENARY SESSIONS:** |
| | ACUTE PROBLEM ROUND TABLES |
| | **Sexually Active Adolescents** |
| 3:15 PM — 3:45 PM | COFFEE BREAK* |
| | **School, College and University Issues** |
| 5:30 PM — 7:30 PM | OPEN* |
| **7:30 PM** | BANQUET AND GUEST ENTERTAINMENT |

*POSTER SESSIONS

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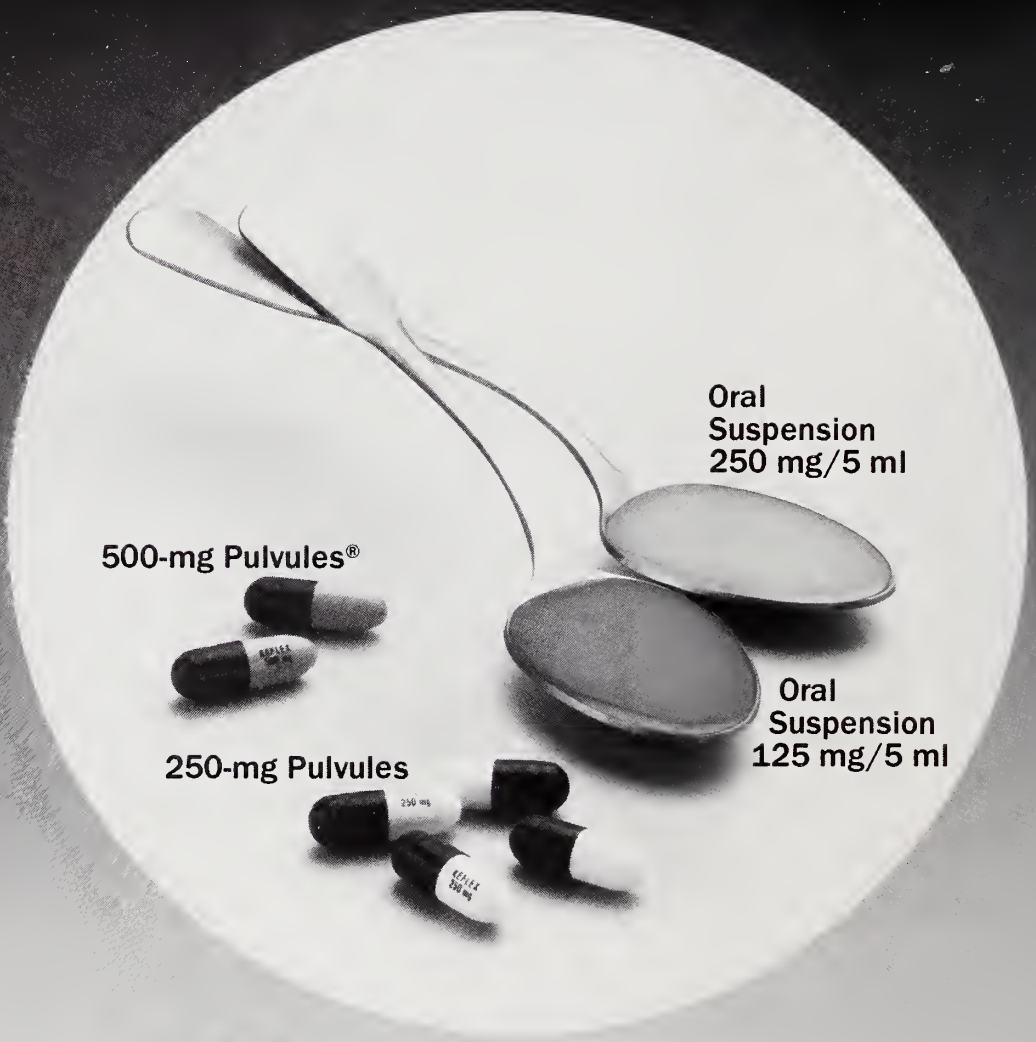


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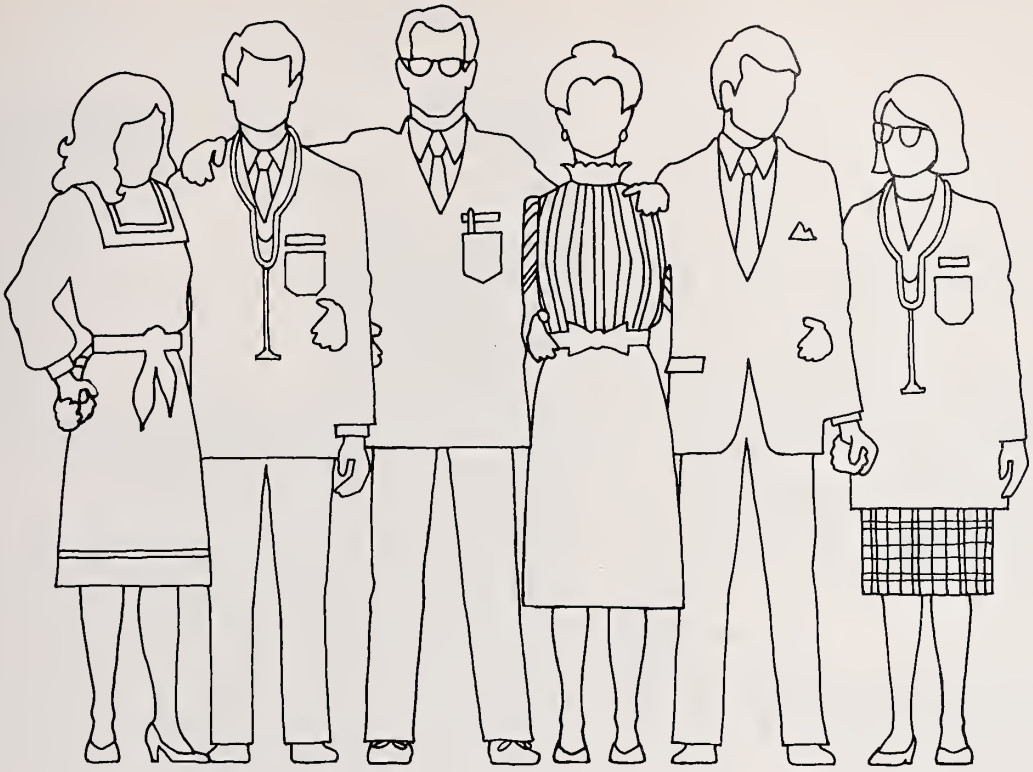

# YOU AND MALPRACTICE STRESS

## *IV: The Office Staff's Perspective*

Rachael Blum, J.D.

WHEN A DOCTOR is sued for professional liability the impact reaches far beyond the physician who is the target of the suit. The doctor's medical assistants, his office staff, may feel the sting of the suit even before the doctor, and perhaps for months or years to come. Previous articles in this series have dealt with the stress of lawsuits from the doctor's perspective (November, 1986) and the spouse's viewpoint (December, 1986). This article will focus on the ramifications for the medical assistant, as they have been reported to me through telephone interviews.

Several variables affect the impact of the doctor's suit on his medical assistant. How and when did the medical assistant first learn of the suit? How did her doctor react to the suit, and how is he handling his own stress? What role, if any, did the medical assistant play in the events which led to the suit? And what role has the medical assistant been asked to play, now that the suit has been threatened or filed?

***"This article focuses on the ramifications of lawsuits (against doctors) for the medical assistant, as they have been reported to me through telephone interviews."***

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If you are out of the office when the summons arrives, your receptionist may be the first to learn of the suit. She may react with surprise, anger, hurt, fear and concern. She may have suspected a suit or she may be totally stunned. If the lawsuit against you involves the medical assistant directly, if it was her error which triggered the suit or contributed significantly to it, then she may be extremely concerned about her own liability. Medical assistants report great anxiety when confronted with having to be deposed and come to court as witnesses. These initial feelings of anxiety may resurface fairly frequently throughout the trial process. She may

feel guilty, and may seriously consider quitting. She may even offer to resign. She may fear your wrath if you blame her, even subconsciously, for having gotten you involved in this whole mess. Even if the bad feelings settle, and the office routine returns to "normal," the anxious feelings could be easily triggered by conversations about the suit, or by new developments in the legal process. She may again offer to quit her job.

***"It may well be your medical assistant's loyalty to you, coupled with her sympathy and good rapport with the patient, that places her in the unique position of being able to talk a patient out of suing you, or help you understand the patient's perspective."***

Medical assistants understand the legal system perhaps even less than you do. Your medical assistants try to protect you — they screen your phone calls, make entries in your chart, zealously guard your valuable time. Medical assistants may find themselves increasingly frustrated with lawyers and the perceived insensitivity of a legal system which not only allows malpractice lawsuits but also allows them to remain unresolved for so long. More specifically, they report feeling angry at attorneys who schedule lengthy depositions for the doctor and then cancel them at the last minute without any apparent awareness of the large gap they have just created in your schedule and the income loss they have caused.

At the same time, your medical assistant may have conflicting feelings of loyalty. She sympathizes with you, her doctor/employer. But she also may sympathize with the patient and family, with whom she has likely developed a good rapport.

It may well be your medical assistant's loyalty to you, coupled with her sympathy and good rapport with the patient, that places her in the unique position of being able to talk a patient out of suing you, or help you understand the patient's perspective. One medical assistant reported actually being asked by her doctor to ask the patient why she wanted to sue another physician. By listening to the patient's whole story and knowing the patient's history, this medical assistant was able to prevent a threatened suit.

How do these feelings and reactions affect the way your medical assistant treats your patients? Medical assistants report being suspicious and overly cautious of all patients as an immediate reaction to their doctor being sued. Some report having trouble sleeping at night, worrying about their role in triggering the suit, and also of what they might be able to do to prevent the patient from suing.

In spite of a lawsuit, and the time and energy it requires of you, your office must continue to function. There are several ways you can help your medical assistant to help you. First, when the summons arrives, she will be very curious. It will probably help her if you let her know at least generally what all the legal documents are about. If you are present when the summons arrives, your medical assistants will respond to your reaction and will follow your lead.

Be careful to acknowledge your feelings to your staff so they can understand the anger and hostility which you may inadvertently direct at them. Let your staff know what they can anticipate to change as a result of this lawsuit. For example, give them guidelines on how to interact with your patient, the plaintiff, and the family, and give them instructions on handling phone calls from attorneys.

***"As the doctor who is sued, help your medical assistants support you — communicate with them about problems as they arise, invite them to listen to patient's complaints from their special role. . . ."***

One medical assistant commented that medical assistants of the specialist tend not to listen to the whole patient. The suggestion was made that medical assistants can assist in taking more thorough histories and listening to the patient's concerns and anger. Even if a suit is already filed, such conversations could provide useful insight.

As the doctor who is sued, help your medical assistants support you — communicate with them about problems as they arise, invite them to listen to patients' complaints from their special role and be sensitive to at least acknowledge that some of the irritations you may direct at them after a suit are not their fault. Share your own anxiety with your office staff so they can feel free to share their concern with you — you can survive it better if you acknowledge that you are going through it together. ■

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# Legal Issues Involving AIDS

*James H. Coil, III*

*As AIDS continues to challenge science, the legal problems facing our society, and especially physicians, continue to multiply. Not only must physicians face medical ethics questions such as, "Do I inform an unknowing spouse that her husband is infected?", but also, as employers, physicians must answer questions related to their employees, those who might have this disease or those who balk at dealing with patients who do. How does a physician handle a situation where a technician refuses to draw blood?*

*This article was solicited by MAG to assist physicians as they face these new conflicts. The author, Mr. Jim Coil, is considered to be one of Georgia's leading legal experts on AIDS.*

*Senator Richard L. Greene*
*MAG's General Counsel*

## Introduction

THE AIDS EPIDEMIC has struck a world that is largely unprepared to deal with its devastating consequences. Ten years ago the disease was unknown in this country. Today, there are more than 25,000 reported cases of AIDS in the United States. By most estimates, cases of AIDS-Related Complex (ARC) exceed ten times that number, and as many as 2,000,000 Americans have been exposed to the virus (HIV) that causes AIDS and ARC.

Many of the legal issues concerned with AIDS involve a conflict between the rights of the individual and the interests of society at large. For example, should school systems admit students and teachers with AIDS, ARC, or seropositive test results to the classroom? Should penal institutions identify and isolate prisoners who have AIDS, ARC, or test positive for HIV exposure? Should a divorced spouse infected with HIV, ARC, or AIDS be denied parental visitation rights to his or her child? May insurance companies require a blood test for HIV exposure in connection with an application for insurance and exclude certain high risk groups from coverage? Courts and legislatures increasingly will have to decide how to strike the balance between every citizen's right to personal freedom and privacy, and the public's need to identify the incidence and to control the spread of infection.

As the segment of society having the most frequent contact with victims of this disease, health care professionals will have to become particularly sensitive to the legal issues surrounding AIDS in a number of contexts. As employers, they will have to deal with special personnel problems associated with AIDS in the workplace. And, as medical experts, they will be called upon for advice by other employers attempting to deal with AIDS-associated problems of their own. Physicians and other health care professionals are already subject to a number of existing state statutes and regulations dealing expressly with AIDS. By virtue of their expertise, they are sure to play a major role in the development of future laws designed to cope with this disease. Finally, physicians and other health care providers must be sensitive to the fact that the unique characteristics of AIDS may increase the risk of liability for health care services and may create special duties owed by a physician to AIDS patients and third parties. Because the disease is so new, its legal ramifications are still developing. To date, there are very few answers. Nevertheless, the questions deserve consideration by everyone involved.

## Employee-Related Issues

The AIDS epidemic has created many legal problems for employers, and in this respect, employers in the health care industry are no different than employers in any other segment of society. Faced with the prospect of AIDS in the workplace, an employer must address a number of difficult issues involving potential liability. For example, may an employer discharge or refuse to hire someone who has AIDS, has ARC, or is seropositive? Can an employer isolate such an

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:mployee from other employees or emove him from a job involving :ontact with the public? What can and vhat should a hospital or physician do f a nurse refuses to be assigned to AIDS patients or if co-workers refuse o work with an employee who has AIDS? Will the increase in the cost of providing medical or disability benefits o an AIDS victim justify the lischarge of or refusal to hire such an ndividual? May an employer screen applicants or employees for HIV exposure?

***"Many of the legal issues concerned with AIDS involve a conflict between the rights of the individual and the interests of society at large."***

Several states, including California and Wisconsin, have statutes prohibiting the use of HIV blood test results in employment decisions. A number of municipalities have enacted ordinances prohibiting discrimination on the basis of AIDS or HIV exposure. To date, neither Georgia nor any of its municipalities has enacted such laws or ordinances.

In the absence of a specific statute or ordinance, the primary laws relating to AIDS in the employment context are those prohibiting discrimination based on a handicap. All 50 states have such statutes, most of which apply to all employers in the state, and at least 33 states have indicated that they will accept AIDS-related claims under their handicap discrimination laws. In states where AIDS is considered a protected handicap, employers generally may not discharge, refuse to hire, or otherwise discriminate against an individual with AIDS or ARC, providing the individual is capable of performing the job in question. In some states, the protection of the handicap discrimination laws extends to persons who are merely *perceived* to have a handicap, regardless of whether they are actually impaired. In such states, the handicap discrimination laws would probably apply to persons who have merely tested positive for HIV exposure but who do not have any clinical symptoms of AIDS or ARC.

The Georgia Equal Employment for the Handicapped Code[1] provides, at best, only limited protection to employees with AIDS or ARC. The law does not appear to prevent employers from testing and discharging employees who are merely seropositive or from rejecting applicants who have AIDS, ARC, or are HIV carriers. It may also permit an employer to take action against an employee with AIDS or ARC, if based in good faith on a physician's recommendation. So far, however, there have been no reported decisions by Georgia courts dealing with the statute in the context of a communicable disease.

***"As the segment of society having the most frequent contact with the victims of this disease, health care professionals will have to become particularly sensitive to the legal issues surrounding AIDS in a number of contexts."***

Handicap discrimination in employment is also prohibited by the federal Vocational Rehabilitation Act of 1973.[2] Several administrative rulings and one federal district court in California have held that the Rehabilitation Act prohibits discrimination based on AIDS, and the language of the statute appears broad enough to protect ARC victims and seropositive individuals as well. However, there is still some dispute over whether the communicable nature of AIDS affects the application of the

Act. The question of whether the Rehabilitation Act applies to communicable diseases may be resolved this year in a case before the U.S. Supreme Court *(Arline v. School Board of Nassau County)* involving a teacher with infectious tuberculosis. Even if AIDS is a protected handicap, the Act does not apply to all employers. It applies only to federal agencies, employers with federal contracts or subcontracts in excess of $2,500, and recipients of federal financial assistance or grants. The latter category would encompass many hospitals and health care facilities. However, only the specific programs that directly or indirectly receive federal financial assistance are subject to the nondiscrimination provisions of the Act.

***"In the absence of a specific statute or ordinance, the primary laws relating to AIDS in the employment context are those prohibiting discrimination based on a handicap."***

In addition to the handicap discrimination statute, several other federal laws may apply to employment decisions based on an individual's AIDS or seropositivity status. For example, it is likely that a discharge to avoid future medical claims for AIDS would violate a federal law called the Employee Retirement Income Security Act ("ERISA"),[3] which prohibits employers from discharging or disciplining an employee for the purpose of depriving him of benefits to which he might be entitled under an employee benefit plan. Because approximately 75% of the AIDS victims in this country have been male, a policy of excluding AIDS victims or seropositive individuals from employment would disproportionately affect men and, absent a compelling business need for the policy, might violate Title VII of the Civil Rights Act of 1964,[4] which prohibits employment discrimination on the basis of sex. Constitutional principles of equal protection and due process also provide additional restraints on the actions of local, state, and federal governments in their treatment of public sector employees.

Legal considerations associated with the employment of AIDS and ARC victims or seropositive individuals are not limited to the employer's treatment of such individuals. Employers must also deal with the reaction of fellow employees. Because of the public's fear of AIDS, co-employees may object to working with an AIDS/ARC victim or someone who is infected with HIV. In the health care industry, similar problems may arise if employees refuse to care for an AIDS patient. Clearly, the degree to which an employer has prepared its workforce to receive or tolerate a person with AIDS will have a bearing on the reaction of employees who are asked to work next to someone with AIDS, and may reduce or eliminate confrontations requiring the employer's intervention. However, if such problems do occur, the employer may not have a completely free hand in dealing with them.

Where two or more employees acting together refuse to work near a person suffering from HIV infection, AIDS or ARC — because of their fear of contagion — they may be protected from discharge or discipline by the National Labor Relations Act ("NLRA").[5] This Act applies to most employers, including hospitals and nursing homes, and protects employees' concerted activity engaged in for mutual aid and protection. Where a single employee acts alone, the employee's refusal to work around an AIDS/ARC patient or HIV carrier will be protected only if the action is authorized by and on behalf of other employees, or if it is for the purpose of enforcing a collective bargaining agreement. If such activity is protected by the NLRA, the participating employee or employees cannot be discharged or disciplined for such conduct. They may, however, be "permanently replaced" by someone else who is willing to perform the job as requested. The distinction between discharging and replacing the employee is more than semantical. If the replaced employee later makes an unconditional offer to work without restriction, he or she must be offered the next available job opening.

If an AIDS or ARC victim or a seropositive individual is present in the workforce, employers should not identify that individual to other employees unless there is a compelling need for such identification. Disclosing an employee's medical condition to other employees may subject the employer to a lawsuit for invasion of privacy. Courts have recognized that an employee may have a claim for invasion of privacy based on an employer's public disclosure of true, private facts about the employee. Because there is apparently no danger of HIV transmission in the normal workplace situation, the employer would probably have no justification for the public disclosure. Moreover, if the disclosure of HIV infection or AIDS is inaccurate, as would be the case with a false positive blood test or a misdiagnosis of AIDS, the employer might also be liable to the employee for defamation.

### Medically Oriented Statutes and Regulations

In addition to employment issues, the AIDS epidemic has raised a number of legal issues for physicians in their roles as providers of health care services. Statutes or regulations in all 50 states require physicians and hospitals to report a diagnosis of AIDS to health authorities. In Georgia, all physicians and the chief administrative officer of all hospitals, nursing homes and clinics are required to report all individuals meeting in the CDC's surveillance definition of AIDS to the Georgia Department of Human Resources.[6] Health care professionals making such reports in good faith

*"To prove negligence, plaintiff would have to show that the health care provider violated the guidelines for blood banks issued by the American Association of Blood Banks or other regulatory bodies."*

cannot be held liable for civil damages as a result of the report.[7]

Laws in Colorado, Idaho, and Montana require physicians to report positive HIV tests to state health authorities. Moreover, physicians in Idaho and Montana must report even suspected cases of HIV infection. Georgia currently does not require reports of HIV infection or ARC cases. However, when an individual who has been diagnosed as having AIDS dies in a hospital or other health care facility, a new Georgia statute requires the attending physician to prepare a written notification of that diagnosis to accompany the body when it is picked up for disposition.[8] The statute further provides that information contained in the required notice shall be confidential and may not be disclosed except in a few specified situations.[9]

*"Disclosing an employee's medical condition to other employees may subject the employer to a lawsuit for invasion of privacy."*

The Georgia General Assembly and the Georgia Department of Human Resources have considered a number of other proposed bills and regulations relating to AIDS. During the 1986 legislative session, the Georgia General Assembly enacted a statute authorizing the closing of bathhouses at which sexual activities occur with the knowledge of the management. The General Assembly considered, but did not pass, bills that would have required premarital blood tests for HIV exposure, classified AIDS as a venereal disease, and authorized a person to supply his or her own blood donors. More recently, the Georgia Department of Human Resources is considering a set of regulations that would require the testing of convicted male and female prostitutes for HIV exposure. The regulations may also require private physicians, hospitals, and other health care providers to offer counseling, HIV testing, and other medical support services to certain high risk pregnant women and individuals who may become pregnant. It is clear, given the catastrophic implications of this disease, that there will be many more proposals before the General Assembly and the Georgia HRC designed to deal with this issue.

**The Business Implications of AIDS**

The AIDS epidemic also poses special legal concerns in areas already familiar to the health care industry. Physicians are under a legal and ethical duty to maintain the confidentiality of their patients' medical records. Maintaining confidentiality is particularly important with respect to AIDS because the prospect of public disclosure might drive AIDS victims and seropositive individuals underground to avoid discrimination and social obstracism. However, physicians of AIDS patients or seropositive individuals may be faced with a moral and legal dilemma if the physician is aware that the patient is continuing to have sexual relations and is not informing his or her sex partner of the risk of infection. Should the physician warn known sex partners of a patient's condition? Such disclosure might subject the physician to liability to the patient for invasion of privacy. However, failure to warn people who are in danger of infection might also subject the physician to liability. In a much publicized lawsuit, a man who claimed to have had a sexual relationship with actor Rock Hudson after the actor was diagnosed as having AIDS sued Hudson's estate, his secretary, and his physicians for conspiracy to conceal their knowledge of Hudson's illness from his sex partner. That case is still pending, and there are no simple answers to the issues it raises.

Another major legal issue facing the health care industry is the liability for the transmission of HIV through contaminated blood products. Prior to May, 1985, when screening of the nation's blood supply for HIV infection began, many individuals became infected through blood transfusions and the use of blood products. Despite the screening measures now in effect, some contaminated blood continues to pass into the nation's blood supply. Forty-five states, including Georgia, have enacted statutes that classify blood as a "service" and not as a product. On the basis of such statutes, courts have refused to apply the strict liability theory and have required plaintiffs to show that the health care providers were negligent in providing contaminated blood.[10] To prove negligence, a plaintiff would have to show that the health care provider violated the guidelines for blood banks issued by the American Association of Blood Banks or other regulatory bodies. Thus, if a blood bank or health care provider adheres to the recommended screening procedures for HIV contamination, it is probably protected from liability for HIV infection through blood transfusions and services.

***"Should the physician warn known sex partners of a patient's condition? Such disclosure might subject the physician to liability to the patient for invasion of privacy. However, failure to warn people who are in danger of infection might also subject the physician to liability."***

### Conclusion

The AIDS epidemic has already created many complex legal issues affecting the health care industry, and the escalating number of cases is likely to create even more problems in the near future. Because AIDS is such a recent phenomenon, little case law dealing with these issues currently exists. The legal community, therefore, has only limited resources on which to rely in addressing the issues associated with this devastating disease. However, with an awareness of the major legal concerns associated with AIDS and the advice of legal counsel, health care providers should be personally able to avoid many of the legal pitfalls generated by the AIDS epidemic and to assist businesses and lawmakers in the development of laws and solutions to the crisis that deal humanely with the victims of this disease and, simultaneously, preserve the balance between individual rights and societal self-preservation.

### Notes

1. O.C.G.A. sec.s 34-6A-1 to 34-6A-6.
2. 29 U.S.C. sec.s 701 to 796.
3. 29 U.S.C. sec. 1140.
4. 42 U.S.C. sec. 2000e *et seq.*
5. 29 U.S.C. sec.s 157 and 158(a)(3).
6. O.C.G.A. sec. 31-12-2(a); Ga. Admin. Comp. ch. 290-5-3-.02(1).
7. O.C.G.A. sec. 31-12-2(b).
8. O.C.G.A. sec. 31-21-3.
9. O.C.G.A. sec. 31-21-3(c).
10. *See, e.g., Hyland Therapeutics v. Superior Court of California*, No. H001204 (Cal. Ct. App., Dec. 10, 1985). The Georgia blood services statute expressly provides that persons participating in the transfusion or transfer of blood products shall not be liable for damages unless negligence is proven. O.C.G.A. sec. 51-1-28(a).

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Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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Revised, April 1982. 5685


1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med,* 141:293-300, 1981.



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# Unproven Methods of Treatment

*Thomas W. Phillips, M.D.*

HERE ARE approximately 100 fferent types of cancer ranging in ulence from basal cell carcinoma of e skin to small cell carcinoma of the ng. There are probably as many fferent causes of cancer as there are fferent types of cancer. Treatment ould be based upon cell type, stage, fferentiation, sensitivity, and the tient's ability to tolerate the atment. But many people still have misconception that cancer is a single sease, like tuberculosis, smallpox, lio, etc. Because of this isconception, most people think that ncer is treatable like a single sease. That is why physicians are nstantly asked, "Will there ever be cure for cancer?"

I think that this misconception is the ngle most important contribution to e perpetuation of unproven methods treatment of cancer patients. The harlatan treats all cancers the same. e then uses testimonials of "cured" atients to prove success. This panacea proach combined with testimonial roof should be a "tip-off" to anyone.

Another important factor that leads a atient to quackery is a feeling of opelessness. The surgeon can't perate, the radiation oncologist can't ive additional treatment, and the edical oncologist either has no ffective drugs or has found the atient's malignancy to be nresponsive. So the patient is literally illing to try anything that gives any ope for improvement or cure. The harlatan offers just what the patient vants to hear, i.e. claims of cure roven by testimonials.

Dietary treatment is very common today. This type of unproven method may occur during a course of standard treatment with radiation or chemotherapy because of the prolonged treatment time involved. There may be weeks or months between actual treatments. The patient becomes concerned that "nothing is being done" in the interim and therefore seeks advice from well-meaning friends and relatives. Much has been written in the medical and lay literature regarding a possible relationship between diet and cancer. But these studies are mainly concerned with a causal relationship rather than a therapeutic relationship. The charlatan capitalizes on the inference and claims cures affected by "metabolic therapy," "megavitamins," "holistic" or "natural diet therapy," and of course, he always has testimonial proof of his success.

We, as physicians, may be able to prevent some of our patients from falling into this unfortunate and sometimes lethal trap. I would suggest the following:

- When the diagnosis of cancer has been made, the physician should spend enough time with the patient to explain that cancer is not a single disease, that there are many different types of cancer and that treatment should be based on the types and stages of the disease. The physician should attempt to dispell misconceptions a patient and or family may have *before* treatment.
- Although a patient may be incurable, it is a mistake to leave him or her with no hope at all. Reassuring the patient that supportive care will be available as needed may be sufficient to avoid a feeling of helplessness. Other patients may require psychosocial counselling to cope with an incurable situation.
- During treatment for cancer, dietary counselling may be very helpful. In most unproven methods, there is some dietary aspect. An example is the "metabolic therapy" associated with laetrile. By focusing on the diet, the patient feels that "something is being done." So, between chemotherapy courses it might be wise to have the patient see a dietician so that "something is being done" rather than having the patient waiting for a month while nothing, apparent to the patient, is happening.

I think the major point to all this is that we can prevent the patient from seeking help from the unscrupulous by doing our part to achieve more effective communication with our patients. We must strive for excellence in treatment of the cancer patient but we should never forget the importance of communication as an integral part of the treatment.

Dr. Phillips is Director of Radiation Oncology, Crawford W. Long Hospital, 25 Prescott St., Atlanta, GA 30365.

This paper was sponsored by the Georgia Division of the American Cancer Society. Those wishing to contribute papers to the CANCER section should send them to Thomas W. Phillips, M.D., CANCER Section Editor, 25 Prescott St., Atlanta, GA 30365.

# Cardiac Transplantation in Georgia

*G. Lionel Zumbro, M.D., Gail Harville, R.N., Ronald F. Galloway, M.D., William R. Kitchens, M.D.*

***"The purpose of this article is to review the historic development as well as the current clinical application of cardiac transplantation in our state."***

CARDIAC TRANSPLANTATION has been a clinical reality for nearly 19 years; however, only recently has it been recognized as therapeutic rather than experimental. During the past 4 years there has been a dramatic increase in the number of hospitals performing cardiac transplants. Today, heart transplantations have been performed at more than 70 hospitals. On June 27, 1984, the first orthotopic cardiac transplantation operation in Georgia was performed at University Hospital, Augusta, Georgia. Through October 7, 1986, 22 cardiac transplants in 19 patients have been performed at University Hospital. Since that time, Emory University Hospital has begun a cardiac transplant program. Currently, Emory and University Hospital are the only two institutions at which this procedure is performed in Georgia. The purpose of this article is to review the historic development as well as current clinical application of cardiac transplantation in our state.

*Historical Review*

The first human-to-human cardiac transplant was performed by Christiaan Barnard at Groote Schuur Hospital, Cape Town, South Africa, Decembe 2, 1967.[1] Prior to this spectacular event, much experimental work had been performed, especially by Drs. Norman Shumway and Richard Low who perfected the surgical technique of orthotopic cardiac transplantation. In the year following Barnard's operation, over 100 cardiac transplar were performed around the world. Most of the patients died within the first year following surgery from rejection and/or infection. Because o poor survival of patients, many doct stopped performing cardiac transplantation until recent years.

Cardiac transplantation continued t be performed, however, on an experimental basis at Stanford University, Medical College of Virginia, and Cape Town, South Africa. In this country, Dr. Shumway's group at Stanford slowly began to experience improved results with long-term survival. By 1980, th 1-year survival rate had reached 70 percent. Since that time, survival has risen to the current 80-90 percent at one year. The main factors accountin for increased survival of patients undergoing cardiac transplantation ar listed in Table I.

*Indications*

Patients with terminal heart failure (NYHA class IV) not amendable to conventional surgery or vigorous medical treatment are considered for

Dr. Zumbro is a cardiovascular surgeon, Ms. Harville specializes in cardiac transplantation, Dr. Galloway is a thoracic surgeon, and Dr. Kitchens is a cardiovascular surgeon at University Hospital in Augusta. Send reprint requests to Dr. Zumbro at 820 St. Sebastian Way, Ste. 2D, Augusta, GA 30902.

This paper was sponsored by the Georgia Affiliate of the American Heart Association.

**TABLE I — Factors Allowing Increased Survival**

1. **Better selection of patients**
2. **Better understanding of rejection and infection**
3. **Availability of antithymocyte globulin**
4. **Developmental of serial endomyocardial biopsy to monitor rejection.**
5. **Discovery of the anti-rejection drug, Cyclosporin**

**TABLE II — Contraindications to Heart Transplantation**

1. **Active infection**
2. **Malignancy**
3. **Age greater than 55 years (relative)**
4. **Recent pulmonary infarction**
5. **Active peptic ulcer**
6. **Severe peripheral vascular disease**
7. **Irreversible damage to major organs (liver, lungs, kidneys)**
8. **Insulin-dependent diabetes (relative)**
9. **Pulmonary hypertension (relative)**

ardiac transplantation. Physiologic ge is more important than chronologic ge; however, most suitable patients ill not exceed 55 years.

Approximately 50 percent of the atients have the diagnosis of liopathic cardiomyopathy, and the emaining 40-50 percent have ischemic ardiomyopathy. Only a small fraction f patients have congenital heart isease. There were two congenital eart patients (one tricuspid atresia and ne anomalous origin of left main oronary artery from pulmonary artery) mong our 19 patients.

*Recipient Selection*

Recipients are selected according to a specific set of criteria and are reviewed by a transplant committee at our institution. Table II lists contraindications to cardiac transplantation.[3] No patient has failed to undergo a cardiac transplant at our institution because of a lack of funds. Although this has resulted in significant financial loss to our institution, we continue to offer cardiac transplantation based on medical needs, without consideration of the ability to pay. Long range planning is underway to offset these losses.

*Donor Selection*

The current availability of efficient resuscitation facilities after injury or acute organ failure has created a situation where patients may receive artificial ventilation and maintenance of circulation without any possibility of recovery of cerebral function. The patient is declared brain dead when there is clinical evidence of absence of brain stem function. Once the donor is declared brain dead, maintenance of vital organ function is critical and often requires large intravascular volume replacement due to the onset of diabetes insipidus. In general, donors should be less than 40 years old with absence of infection, malignancy, cardiac disease, or injury.[4]

*Technical Aspects*

Once the donor heart is excised, it is placed in cold (4°c) physiologic solution in a sterile container. The donor heart can then be transported and preserved for at least 4 hours. Usually orthotopic transplantation is performed; however, in the presence of recipient pulmonary hypertension or a small donor heart, heterotopic transplantation may be performed. We have done 18 orthotopic transplants and 4 heterotopic transplants in 19 patients.

*Orthotopic Transplantation*

An orthotopic transplant is performed when a recipient's heart is excised and the donor heart sewn into its natural location. This is the simplest and most frequently performed technique of heart transplantation today. The orthotopically transplanted heart should function satisfactorily unless severe pulmonary hypertension exists. This will cause immediate right ventricular failure at the time of transplantation. We had this unfortunate experience in one patient who required mechanical right ventricular assistance for survival.

*Heterotopic Transplantation (Piggyback heart)*

Under special circumstances, the donor heart is sewn in parallel to the recipient heart (Figure 1). Two of the most frequent indications for heterotopic transplantations are pulmonary hypertension (pulmonary vascular resistance greater than 8 Wood units) and a donor heart that is found to be too small for the recipient. One of our patients is now in his second postoperative year with a heterotopic transplant. His own heart continues to function to a slight degree but most of his cardiac output is from the transplanted heart.

*Immunosuppression*

Cyclosporin and prednisone continue to be the mainstay of immunosuppression at most transplant centers. We have recently added low dose Azathioprine (0.5-1mg/kg) to the Cyclosporin and steroid regimen. Rabbit antilymphocyte globulin and Orthoclone OKT3* are added as rescure therapy for recalcitrant rejection. Rejection is monitored by frequent endomyocardial biopsy (weekly for first 3 months). Echocardiography offers a promising new method of following rejection noninvasively. Shortening of the isovolumic relaxation period (period of time from aortic valve closure to opening of mitral valve) correlates well with early rejection.

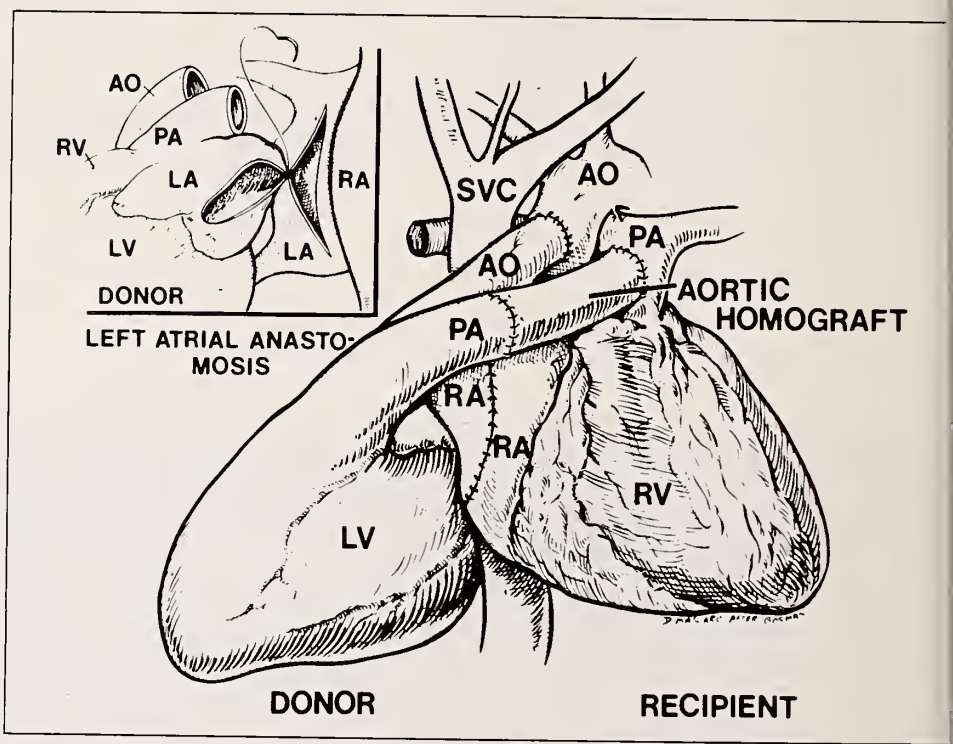


*Figure 1 — Heterotopic Heart Transplant: Note insert demonstrating side to side anastomosis of donor and recipient left atria. Right atrial and end to side aortic anastomosis seen in the main figure. Note homograph necessary to gain adequate length for pulmonary artery anastomosis.*

*The Role of Mechanical Hearts and Assist Devices*

A few patients experience sudden severe hemodynamic deterioration while awaiting a donor for cardiac transplantation. These patients face certain death unless mechanical cardiac support can be provided.[5, 6] Intra-aortic balloon pumping, ventricular assist devices, and the total artificial heart are of increasing importance in salvaging these desperately ill patients. Recent experience has resulted in excellent survival when these devices are used as a bridge to cardiac transplantation. During the first 6 months of 1986, we performed two bridge-to-transplant procedures. One patient received 36 hours of support with a prosthetic ventricle† before undergoing orthotopic transplantatio The second patient was supported fc 4 days with a centrifugal pump‡ before successful transplantation. Bc patients were discharged from the hospital and are doing well. The use of mechanical devices as a bridge to cardiac transplantation creates an enormous ethical dilemma in view o the limited donor heart supply. Only future controlled studies will provide accurate answers to this dilemma.

* Ortho Pharmaceutical Corp., Raritan, New Jersey
† Pierce Donachy Pump, Thoratec, Inc., Berkeley, California
‡ Biomedicus Inc., Eden Prairie, Minnesota

*Results of University Hospital Program*

Like many cardiac transplant programs, we experienced an early learning curve, with three operative deaths (death prior to hospital discharge) occurring in our first eight patients. In retrospect, some of these patients were not ideal candidates for cardiac transplantation, and at least one death was due to our lack of aggressiveness in treating acute rejection. With time and experience, results have improved dramatically. Since our initial 3 operative deaths, all patients have survived surgery (11 consecutive patients) and were discharged from the hospital. In our most recent experience from January 1, 1986, to October 7, 1986, we performed 9 transplants, with 8 patients currently alive and doing well. One of the 9 patients died five months postoperatively of *Pneumocystis carinii* and cytomegalovirus pneumonia. The short-term and long-term care of these patients continues to be highly demanding for both the transplant recipient and the physician. Despite the highly demanding nature of a cardiac transplant program, we believe that it is a service badly needed by a few select patients with endstage heart disease and therefore plan to continue offering the procedure to our patients.

*Summary and Conclusions*

Over the past 19 years, cardiac transplantation has developed into an accepted and effective treatment for terminal heart disease patients who face certain death as the only alternative. Improved selection of management of patients has resulted in the current survival rate of 80-90 percent of patients at one year and 50 percent at 3-5 years. These patients experience excellent physical rehabilitation in most cases. Greater public awareness of the shortage of donor organs, improved donor heart preservation, and the use of mechanical devices for cardiac support will result in a greater number of patients undergoing cardiac transplantation. In spite of these advances in technology, donor heart supply will fall short of the number of patients needing cardiac transplantation. Rejection and infections will continue to limit long-term success until more specific anti-rejection drugs are available.

***“Greater public awareness of the shortage of donor organs, improved donor heart preservation, and the use of mechanical devices for cardiac support will result in a greater number of patients undergoing cardiac transplantation.”***

***“Echocardiography offers a promising new method of following rejection noninvasively. Shortening of the isovolumic relaxation period correlates well with early rejection.”***

Cardiac transplantation should not be considered the primary solution to the large number of patients dying from advanced heart failure, but it can provide excellent palliation to a select few who are suitable candidates. The ultimate solution for advanced heart failure will come once we understand the pathophysiology and prevention of heart disease.

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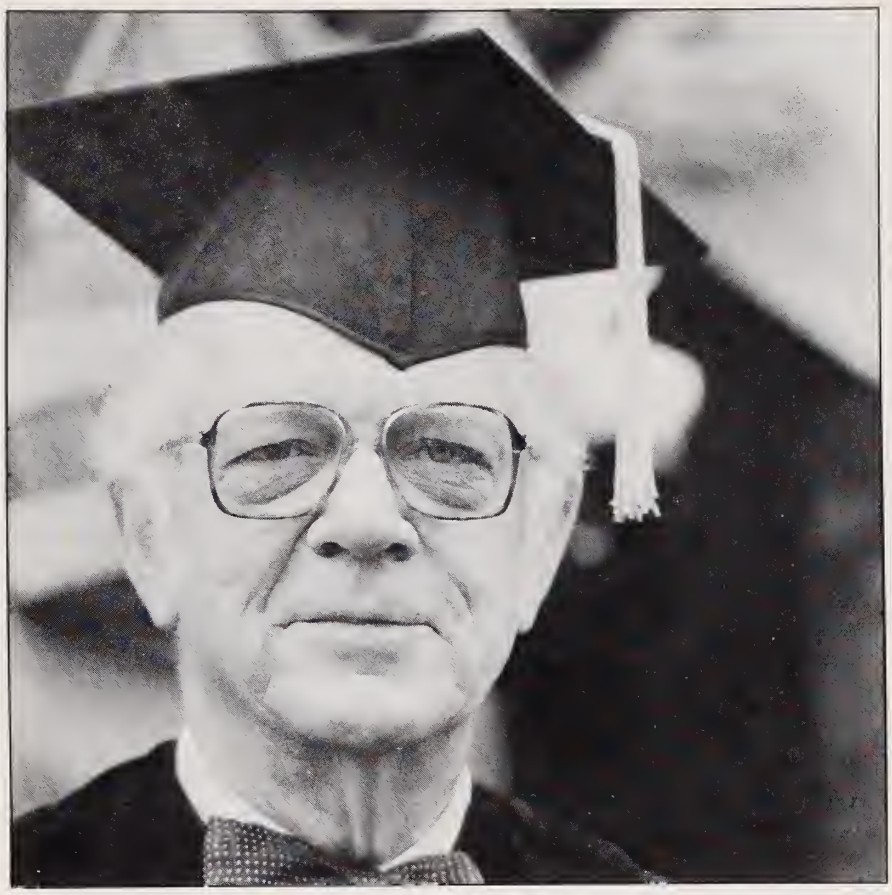

*Harrison L. Rogers, M.D., an Atlanta surgeon, receives honorary degree from Emory University in recognition of extraordinary professional achievement and university service.*

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## PERSONALS

*Fourth District*

**J. R. B. Hutchinson, M.D.,** was selected as president-elect at the annual business meeting of the American Academy of Otolaryngologic Allergy.

**John G. Leonardy, M.D.,** was named president of the Joint Council of Allergy and Immunology at its recent annual meeting.

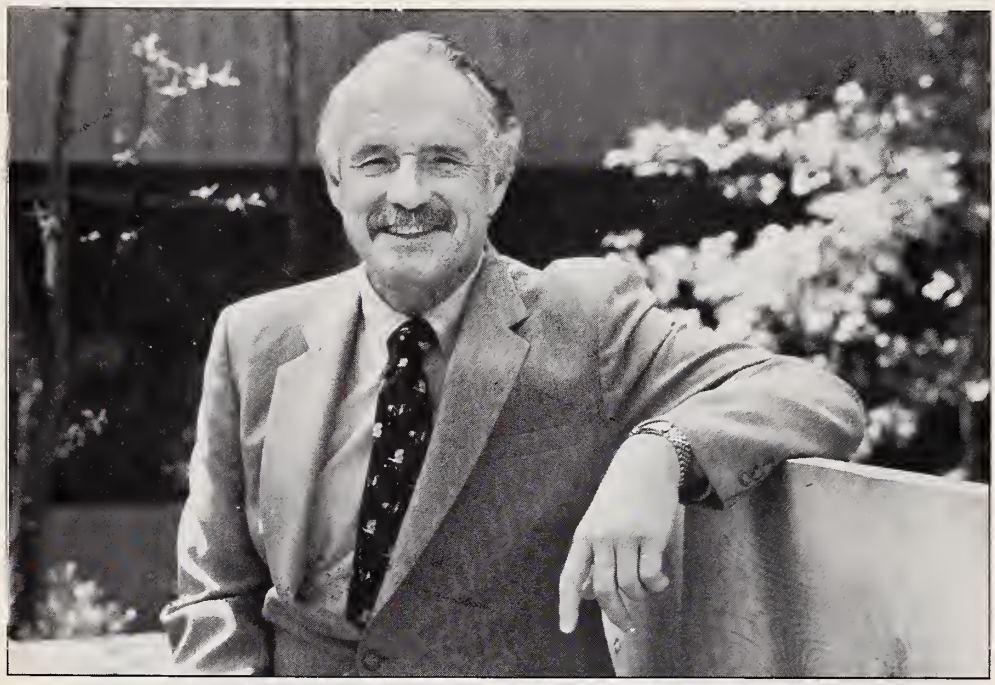
*Fifth District*

**Peter J. Ulbrich, M.D.,** has established an obstetrics and gynecology practice in Atlanta.

**George E. Malcolm Jr., M.D.,** of Roswell was recently elected to Fellow status of the American College of Emergency Physicians.

As part of Emory University's sesquicentennial celebration, **Harrison L. Rogers, Jr., M.D.,** Atlanta surgeon and Immediate Past President of the American Medical Association, was awarded the honorary degree of Doctor of Science. Dr. Rogers was among ten distinguished graduates, chosen from Emory's 52,000 living alumni, who received honorary degrees in recognition of exemplary achievement in a variety of fields.

The awards were bestowed in ceremonies held at the University on November 10. In addition to Dr. Rogers, honorary degrees were given to Ivan L. Benett, M.D., Professor of Pathology at New York University; Charles W. Fain, Jr., President of the American College of Dentistry; and A. B. Padgett, founder of the Caduceus Foundation.



*Internist-addictionologist G. Douglas Talbott, M.D., was awarded the AMA-ERF award for health education at the AMA Interim meeting last December.*

**Robert M. Cohen, M.D.,** has opened an office in Conyers for the practice of allergy, asthma, and clinical immunology.

In 1984, **James C. Tanner, M.D.,** of Atlanta, established the "Tanner-Vandeput Prize for Burn Research," conceived and donated by Dr. Tanner, co-inventor with Dr. Jacques Vandeput of the Tanner-Vandeput Mesh Dermatome. Dr. Tanner estblished this tax-exempt foundation for the purpose of awarding the Prize at each Quadrennial Congress. His intention is to promote the aims of the ISBI and to motivate individual investigators in developed and undeveloped countries to do research in any aspect of the burn field.

The first Tanner-Vandeput Prize was awarded last year to Dr. Ian Alan Holder, Director, Department of Microbiology at the Shriners Burns Institute in Cincinnati, Ohio, for his research project on "Infection by Pseudomonas Aeruginosa" because it was felt that he had made the most outstanding contribution to research in burns.

*Sixth District*

**Joseph W. Parks, III, M.D.,** became a Fellow of the American College of Surgeons at the 72nd annual Clinical Congress of the American College of Surgeons.

**A. A. "Tony" Malizia, M.D.,** a urologic surgeon, has been elected secretary-treasurer of the Atlanta Urologic Society. Dr. Malizia is a member of the clinical faculty of the Emory University School of Medicine and is a staff member of Henry General and Clayton General hospitals.

*Seventh District*

**Martin C. Michaels, M.D.,** has been certified as a Diplomate of the American Board of Pediatrics.

**Jeffeory H. White, M.D.,** has been certified as a Diplomate of the American Board of Pediatrics.

**G. Douglas Talbott, M.D.,** was awarded the AMA-ERF Award for health education at the AMA Interim Meeting in Las Vegas last December.

The Award, consisting of a $3,500 stipend and an appropriate certificate, was established to encourage and recognize the health education activities of practicing physicians. In 1986, special consideration was given to physicians' achievements in alcohol and/or drug abuse. The award is supported by a grant from the John P. McGovern Foundation.

Specializing in the field of addictionology, Dr. Talbott is presently the Director of The Medical Association of Georgia's Impaired Physicians Program and Director of Chemical Dependence Services at Ridgeview Institute in Atlanta. He i recognized as a pioneer and national authority in the treatment of alcohol and drug addiction, with an emphas on impaired physician's and other health professionals.

Other achievements to Dr. Talbot credit include his leadership and rol as President of the American Acade of Addictionology. He is instrument in developing alcohol and drug addiction as a new specific disciplin in medicine which may lead to a ne specialty. In cooperation with the AMA and the American Medical Society on Alcohol and Other Drugs Dr. Talbott has been an intregal part of developing criteria for Certificati in Addictionology.

*Ninth District*

**Melissa Miller, M.D.,** an internis has joined the medical staff at Saint Joseph's Hospital in Dahlonega.

*Tenth District*

**Harry T. Harper, Jr., M.D.,** a cardiologist, was honored at the quarterly board meeting of the University Health Care Foundation. An endowment fund was established his name and will be used to sponso lectures featuring a leading national speaker in the field of cardiology.

## DEATHS

**Joseph Hiram Kite, M.D.,** of Decatur, died at the age of 94.

Dr. Kite was a children's orthopec surgeon who did not stop operating until he was 80 and continued to tre clubfoot children until he closed his office at 89 years of age.

Dr. Kite received his medical deg in 1918 from Johns Hopkins Medica School. After serving several residencies, Dr. Kite joined the staff Scottish Rite Hospital, and in 1928 h became Surgeon-in-Chief at the hospital, a post he held until 1965. A the same time, Dr. Kite was also actively engaged in his private practi of orthopedics, which he established 1928. He was one of the few orthopedic surgeons who limited his interest and practice to children. In 1972, the Lions Club of Decatur named him "Senior Citizen of the Year" for his services to crippled children.

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## QUOTES

*I would feel more optimistic about a bright future for man if he spent less time proving he can outwit nature and more time tasting her sweetness and respecting her seniority.*
E. B. White

*You give but little when you give of your possessions. It is when you give of yourself that you truly give.*
Kahlil Gibran

*Creativity is the act of bringing something new into the world, whether a symphony, a novel, a supermarket or a new casserole. It is based first on communication with oneself, then testing that communication with experience and reality.*
S. I. Hayakawa

*Work is not of course, any more than play, the object of life; both are means to the same end.*
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AMA Auxiliary ..... 63

Air Force Reserve ..... 24

American Cancer Society ..... 23, 54

American Liver Foundation ..... 26

Atlanta Magnetic Imaging ..... 77

Brawner Psychiatric Institute ..... 6

Campbell Laboratories ..... 24

Classifieds ..... 77

Data Plus Corporation ..... 35

Health Quip, Inc. ..... 4

Knoll Pharmaceutical ..... 68A-B

Lilly, Eli & Company ..... 60B

MAG Mutual Insurance Company ..... 2

Marion Laboratories, Inc. ..... 12A-B

Medical Defense Corporation ..... 12

Neuropsychiatric Diagnostic Clinic of Atlanta ..... 60

Reynolds & Reynolds ..... 47

Ridgeview Adolescent Program ..... 23, 25, 27

Roche ..... 79, 80

Scottish Rite Children's Hospital ..... 3

Willingway Hospital ..... 4

Woodridge Hospital ..... 63

UMI Article Clearinghouse ..... 46

Upjohn Company ..... 60A

U.S. Army Reserve ..... 10

Weight Watchers of Greater Atlanta ..... 4


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**MANUSCRIPTS** — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

**STYLE** — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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FEBRUARY 1987

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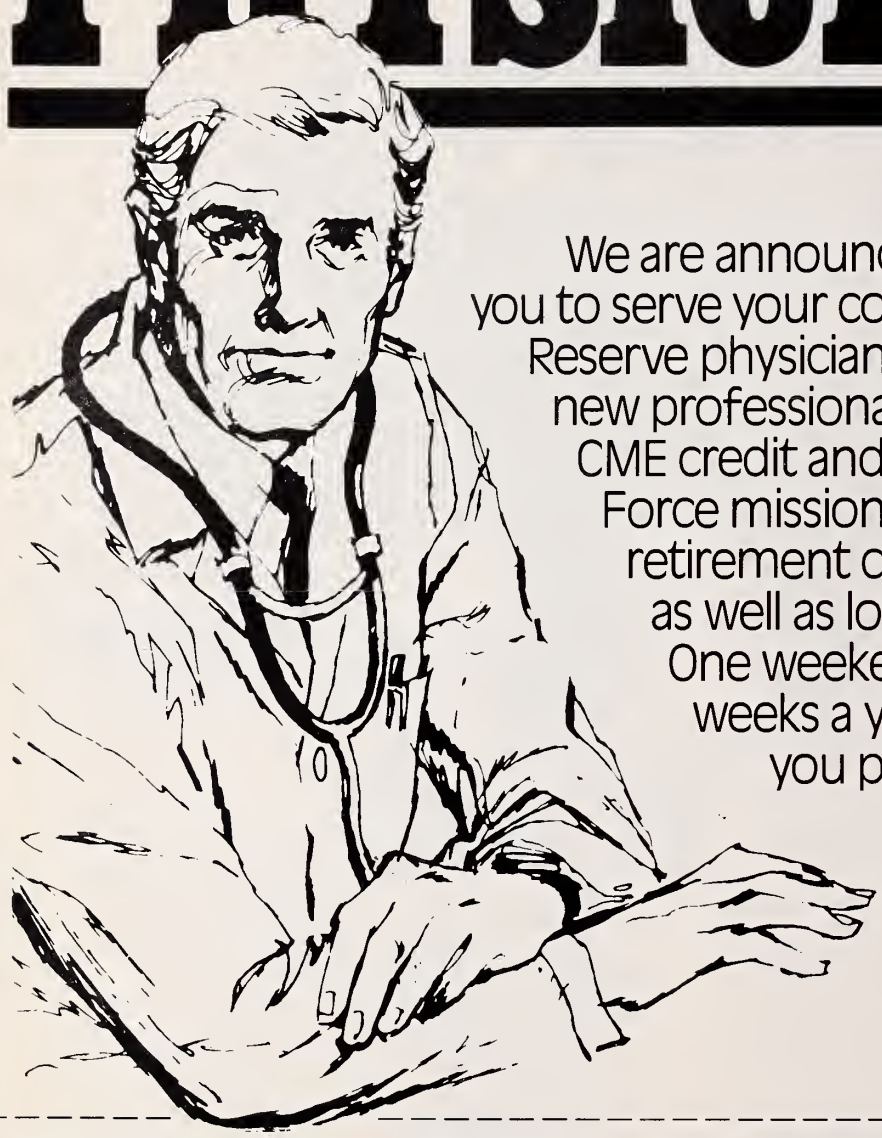

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| OXYCODONE | XX | XX | XX | XX | XX |

**Blank space indicates that no such activity has been reported.**

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.


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# CONTENTS

VOLUME 76, NUMBER 2

## FEATURES

SURGICAL TREATMENT OF VARICOSE VEINS: A DOWNWARD TREND 111
By Milton F. Bryant, M.D., Georges M. Maliha, M.D.

YOU AND MALPRACTICE STRESS: V. A DEATH IN THE FAMILY 115
By Ernest C. Fokes, M.D.

THE EFFECTS OF EXCLUDING <500 GRAM INFANTS ON INFANT MORTALITY RATES IN GEORGIA 117
By Barbara N. Samuels, M.D., M.P.H., Michael R. Lavoie, M.A.

WHAT DOES ALCOHOL CONSUMPTION COST GEORGIA? 125
By Jeffrey J. Sacks, M.D., M.P.H., R. Keith Sikes, D.V.M., M.P.H.

FIFTEEN-YEAR REVIEW OF EXTRACRANIAL CAROTID ARTERY INJURY 129
By Bill H. Moses, Jr., M.D., Mary Ann Tolson, R.N., Carl R. Boyd, M.D.

## EDITORIALS

THE FUTURE OF CARDIOVASCULAR MEDICINE 94
By J. Willis Hurst, M.D.

"ASK NOT WHAT. . . ." 97
By Richard W. Cohen, M.D.

COMMENTS ON INFANT MORTALITY 98
By Luella Klein, M.D.

NEW DRG PROPOSAL EXPANDED TO PHYSICIANS? 99
By U.S. Rep. J. Roy Rowland

## HEART

HEART MONTH: A LOOK AT ACTIVITIES OF THE GEORGIA AFFILIATE 100
By D. Scott MacLeod, M.D.

## X-RAY CHALLENGE

OPPRESSIVE DYSPNEA AND PULMONARY EDEMA IN AN OBESE SOMNOLENT MAN 133
By Bashir A. Chaudhary, M.D., Tesneem K. Chaudhary, M.D., William A. Speir, M.D.

## LEGAL

HOSPITAL PEER REVIEW IN A HOSTILE ENVIRONMENT 138
By Richard Greene

## CANCER

THE GEORGIA DIVISION ENTERS ITS 41ST YEAR 142
By Robert E. Knox, Jr.

## DEPARTMENTS

CALENDAR 86
SOUTHEASTERN SURGICAL CONGRESS • TENTATIVE PROGRAM 87
PRESIDENT'S PAGE 89
EDITOR'S CORNER 91
ASSOCIATION NEWS 146
AD INDEX/MANUSCRIPT INFORMATION 150

## COVER

Heart Month is featured in Dr. J. Willis Hurst's editorial and Dr. D. Scott McLeod's article in the HEART Section. Artwork by Nancy P. Mathews, Medical Illustrations, Emory University School of Medicine, Atlanta.

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9-12 — *Atlanta:* **American Colle of Preventive Medicine and Association of Teachers of Preventive Medicine Joint Meeting.** Category 1 credit. Con Hazel Keimowitz, ACPM, 1015 Fifteenth St., Ste. 403, Washingt DC 20005. PH:202/789-0003.

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### ONDAY
### rch 16, 1987

-8:15 **A.M.** *Complimentary Continental Breakfast in Exhibit Area—Exhibits Open*
**A.M.** *Opening Ceremony*
Keynote Speaker, G. Thomas Shires, M.D., Chairman, Department of Surgery, Cornell University Medical School, New York, NY
SURGERY IN AIDS, Ferguson
AORTIC DISSECTION, Crawford
0 CAROTID ENDARTERECTOMY, Edwards
0 *Break—Exhibits Open*
0 INFECTED AORTOBIFEMORAL PROSTHESIS, Schellack
0 UPDATE ON COLORECTAL CANCER, Leffall
0 LOCAL EXCISION FOR RECTAL CANCER, Ellis
0 THE LASER APPROACH TO OBSTRUCTING LESIONS, Wodnicki
0 **P.M.** Presidential Address, Rumage
0 *Lunch—Exhibits Open*
BILIARY TRACT OBSTRUCTION, Braasch
BILIARY RECONSTRUCTION, Innes
OMENTAL SPLENIC AUTOTRANSPLANT, Steely
FASCIOTOMY FOR TRAUMA, Vitale
*Break—Exhibits Open*
HEPATIC INJURIES, Shires
Panel—TRAUMA
*Adjourn*
President's Panels

### ubby Hole A

**A.M.** CHOLECYSTOSTOMY CALCULOUS AND ACALCULUS, Jurkovich
0 PERCUTANEOUS ABSCESSES DRAINAGE, Ercoli
0 NONPALPABLE XEROMAMMOGRAPHIC ABNORMALITIES, Bauer

### ubby Hole B

**A.M.** PERITONEOVENOUS SHUNT COMPLICATIONS, LeVeen
CARCINOMA OF THE MALE BREAST, Morrison
INTRAOPERATIVE RADIATION FOR HEPATIC METASTASES, Holt

### ESDAY
### ch 17, 1987

:15 **A.M.** *Continental Breakfast in Exhibit Area—Exhibits Open*
**A.M.** Ethicon Film: BREAST-SPARING TECHNIQUES, Greene
**8:50** BREAST RECONSTRUCTION, Bostwick
**9:10** DIAGNOSIS OF UROLOGICAL MALIGNANCY, Hershman
**9:20** MEDULLARY THYROID CARCINOMA, van Heerden
**9:40** ARTIFICIAL SPHINCTER FOR ANAL CONTINENCE, Sophia
**9:50** SCINTIGRAPHY IN LOCALIZATION OF PARATHYROIDS, Opelka
**10:10** ANTIREFLUX SURGERY, Skinner
**10:30** *Break—Exhibits Open*
**11:00** SUTURE FOR PYLORIC EXCLUSION, DeSantis
**11:10** RECURRENT DUODENAL ULCER DISEASE, Kinney
**11:30** PERFORATION IN BLEEDING ULCER, Dasmahapatra
**11:50** EFFECT OF JEJUNAL FEEDING ON GASTRIC pH, Civil
**12:00** PROXIMAL GASTRIC VAGOTOMY, van Heerden
**12:20 P.M.** *Lunch—Exhibits Open*
**1:30** CINE'MED SURGICAL CLINIC
**4:00** *Break—Exhibits Open*
**4:30** FLUID MANAGEMENT, Shires
**4:50** TEMPERATURE AND SURVIVAL IN SHOCK, Sori
**5:30** *Wine & Cheese Party—Exhibits Open*

### Cubby Hole A

**8:50 A.M.** PANCREAS DIVISUM AND PANCREATITIS IN CHILDREN, Watner
**9:40** RESUSCITATIVE THORACOTOMY IN CHILDREN AND ADOLESCENTS, Gill
**11:00** VENTRICULOPERITONEAL SHUNTS, COMPLICATIONS, Bryant

### Cubby Hole B

**8:50 A.M.** CHOLELITHIASIS IN CHILDREN, Holcomb
**9:40** BLUNT DIAPHRAGMATIC INJURY, Dauber
**11:00** RUPTURED ABDOMINAL AORTIC ANEURYSM, Martin

### WEDNESDAY
### March 18, 1987

**7:30-8:15 A.M.** *Continental Breakfast in Exhibit Area—Exhibits Open*
**8:30 A.M.** ABDOMINAL AORTIC ANEURYSMS, Crawford
**8:50** ALBUMIN-IMPREGNATED DACRON PROSTHESIS, McGee
**9:00** NEW COLLAGEN-IMPREGNATED AORTIC GRAFT, Reigel
**9:20** ESOPHAGEAL CARCINOMA, Skinner
**9:40** COMPLEMENT ACTIVATION IN PERITONITIS, Schirmer
**9:50** CT SCANS IN PANCREATIC CANCER, Ross
**10:10** OBSTRUCTIVE DISTAL BILE DUCT LESIONS, Braasch
**10:30** *Break—Exhibits Open*
**11:00** MALIGNANT MELANOMA, Copeland
**11:20** INTRA-AORTIC BALLOON PUMP, Curtis
**11:40** THORACIC OUTLET SYNDROME, Stanton
**12:00** Presentation of Awards
**12:20 P.M.** *Lunch—Exhibits Open*
**1:40** PANCREATIC INFLAMMATORY DISEASE, Nance
**2:00** EVALUATIONS OF INTESTINAL VIABILITY, Dyess
**2:20** CHOLECYSTECTOMY IN THE ELDERLY, Margiotta
**2:40** INTRAOPERATIVE CHOLANGIGRAPHY, Mansberger
**3:00** BLUNT URETHRAL INJURY, Malangoni
**3:20** INTUBATION IN MULTIPLY INJURED PATIENT, Talucci
**3:40** SURGERY ECONOMICS AND PRACTICE, Watkins
**4:00** Panel—LIVER, GALL BLADDER, AND PANCREAS
**5:00** *Adjourn*

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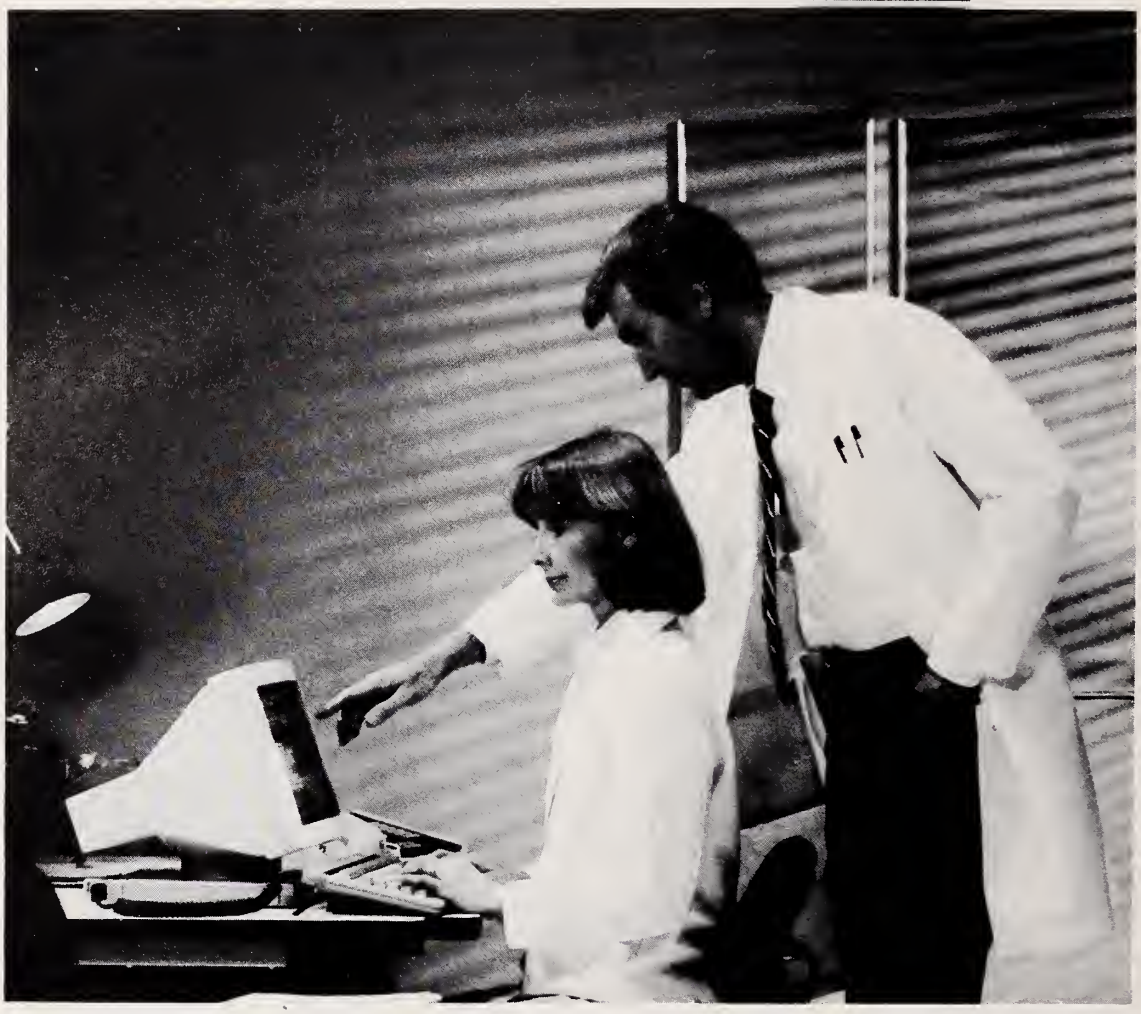

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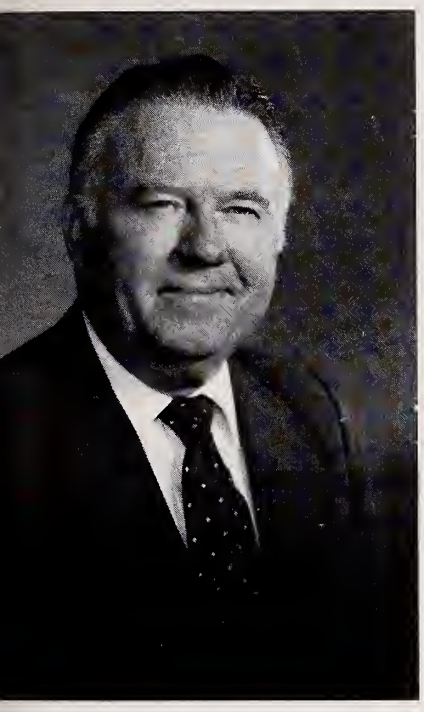

*John D. Watson, Jr., M.D.*

# *Profession or Trade?*

I HAD THE OPPORTUNITY to read a speech recently given by a very prominent lawyer — that's right, a lawyer. It was given to the State Bar of New Mexico on its Centennial celebration program. I could take the speech and replace lawyer or legal with doctor or medical, and I think it would fit as well. This very erudite individual was expressing his views of the loss of professionalism in the legal profession. I will quote extensively from him. He is Simon H. Rifkind, Esq.

Mr. Rifkind was describing the sorry state of respect that lawyers "enjoy" and suggesting that the loss of professionalism was the root of the problem. Are we in the process of the same deterioration? Read and heed these profound insights well and see if the shoe fits.

What characteristics distinguish a profession from a trade?

1. The place of self-interest: the profession excludes it; trade emphasizes it.
2. The relative weight assigned to obligations and rights: the profession assigns great weight to its obligations; trade assigns such weight to its rights.
3. A profession encompasses the obligation to share information with fellow professionals; trade treats private knowledge as a business secret.
4. A profession must be practiced in the spirit of public service; a trade has no such commitment.

I do not mean in any way to compare the present day practice of medicine with the present day practice of law. However, I would be remiss if I did not express my profound respect for the law and the vast majority of truly *professional* lawyers. The *trade* group of lawyers is bringing their profession down just as lack of professionalism is bringing us down. When we place anything before the care and well being of the patient, we place ourselves in jeopardy and loss of confidence of intent.

Why are we now subject to legislative measures more severe than we ever imagined? What have we done to deserve this? Take a close look at yourself and your method of practice. We will soon need to appeal to our patients and the electorate to aid us in our fight against more severe legislation. Will they respond and come to our aid? Have we deteriorated in their perception of just practicing Medicine for self-interest — financial interest? Have we come too far down the road — can we change it? We can and we must, but only *we* can do it. Only when we consistently place the patient first, above all, will we regain our rightful place. We must be the patient's advocate in every measure, no matter what the system, no matter what the occasion. The Sands of Time are dropping; take heed.

Sincerely,

John D. Watson Jr. M.D.

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# "Reform What — Reform Who?"

*"As we look back at he Legislature's efforts nvolving tort reform from his better vantage point hat that of the day when his was written, may we ee that there has been ome happy semblance of ooperation, some nderstanding of each ther's problems, some ecognition of each of our railties and mperfections."*

THE PRACTICAL NECESSITY of publishing deadlines dictates that this be written on the day prior to the opening of the 1987 State of Georgia Legislative Session. It is written in the heady days of controlled enthusiasm relating to Senate Bill No. 1 and No. 2 being introduced on the morrow, sponsored not just by the Lieutenant Governor who has stood forth in the past few months as their companion, but also by the Governor, and signed by no less than 40 or so members of that august body of legislators. It is said that these Bills will be passed out of the Senate with something less than mortal wounds. They will travel to the House of Representatives for further skirmishes. The lion will roar, and the audience shall then pass judgment on the quality of the play.

But then, these words shall be read in the cold, blue light of mid February — in the face of cold reality and what is to be, or shall have been. What, then, are we addressing, this "tort reform." A "tort" — it says, is "A civil wrong, not including a breach of contract, for which the injured party is entitled to compensation." And to "reform" — is to imply that something is not working, or needs repairing, perhaps fine tuning or completely overhauling. This does not seem too unusual, for we started this Republic by "reforming" civil and religious strictures those several centuries ago. We are still at it.

Thus, we must ask ourselves, "Wherein lies the problem? Why the need to reform? Is it the lawyers, the legislators, the courts, the juries, the insurance industry, or Heaven help us, is it 'us'?" Have we "Pogoed" *ourselves*? ("We have met the enemy, and he is us!" — Pogo.) We all have friends in every one of these groups of fallible human beings — we respect and like them, even trust some of them. Perhaps the problem lies a bit with each of these groups of people. We must, as physicians — and we cannot refuse or fail — to hold up our share of the bargain, to adequately and ethically fulfill our own part of the effort. We have a charge, a mission, to provide the very best medical care to the sick and injured that our abilities allow. We have a practical need to maintain that degree of fiscal solvency that allows us to fulfill that mission. We must, all of us, understand that we are not isolated travelers in this matter of health care delivery, but rather members of an ever enlarging team effort required to function effectively.

And so, as we look back at the Legislature's efforts involving tort reform from this better vantage point than that of the day when this was written, may we see that there has been some happy semblance of cooperation, some understanding of each other's problems, some recognition of each of our frailties and imperfections. May we see that there has been a recognition of the need for stability and a necessity for change. May we and our legislators come to realize, as John Stuart Mill told us in the Nineteenth Century, that "a party of order and stability, and a party of progress or reform, are both necessary elements of a healthy state of political life." And if we are cleanly honest with ourselves, may neither we nor the lawyers be the winners, but may the sick and injured of this State be the clear and obvious winners of this effort at "reform."

*Charles R. Underwood, M.D.*
*Interim Editor*

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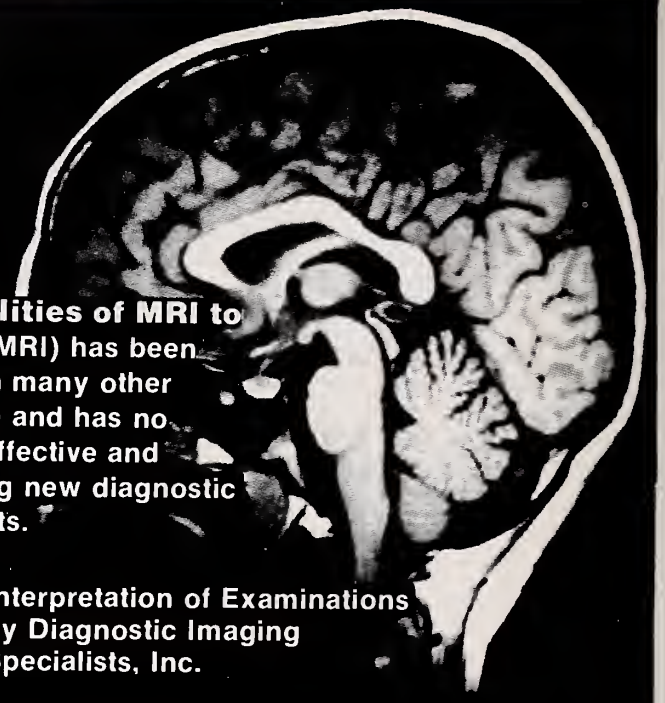

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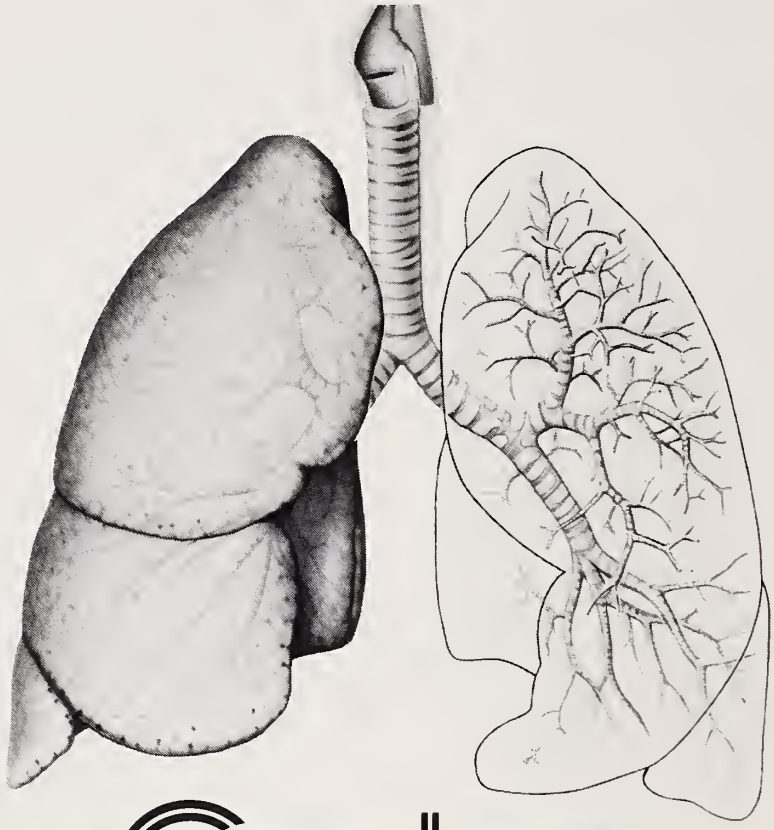

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Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

**Ceclor®** (cefaclor)

**Summary. Consult the package literature for prescribing information.**

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**Warnings:** CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

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- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

**Adverse Reactions:** (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

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- Slight elevations in hepatic enzymes.
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# The Future of Cardiovascular Medicine

THE QUALITY OF CARE delivered to infants, children, and adults with heart disease is not exceeded outside the State of Georgia.

So much for the present. What about the future, here and elsewhere? What will cardiovascular medicine be like in the future?

**Technologic Contributions to Cardiovascular Medicine**

As I analyze how cardiovascular medicine has progressed to its present state, I must conclude that it did so because of technologic advances. The revolution began in 1927 when Forssmann introduced the world to cardiac catheterization by inserting a uretheral catheter into his own arm vein and advanced it into the right atrium of his heart. After a lag of almost 20 years the technique and its companion, angiography, were used to diagnose congenital heart disease, vavular heart disease, and finally, after another lag period of about 20 years, the technique was further refined so that it could be used to diagnose coronary artery disease.

The technology was then developed to permit open heart surgery and other new techniques including: long-term electrocardiographic recording for the detection of arrhythmias, the technique of defibrillation, Holter monitoring, pacemakers, internal defibrillators, clinical electrophysiologic testing, outpatient coronary arteriography, cardiac enzyme detection, cardiac biopsy, nuclear cardiology, coronary angioplasty, and nuclear magnetic resonance. Cardiac surgery was further developed to encompass almost all cardiac conditions including certain cardiac arrhythmias and cardiomyopathy (transplantation and the artificial heart). No one can deny that the progress which has been made in the field of cardiovascular medicine has been largely in the field of technology.

***"As I analyze how cardiovascular medicine has progressed to its present state, I must conclude that it did so because of technologic advances."***

**Future Considerations**

It is safe to predict that the future progress of cardiovascular medicine will also occur because of new advances in technology. This being true leads me to make the following three points:

- If we agree that technology led to where we are in cardiovascular medicine and that high technology w lead us into the future, we must recognize that the technologic activit should not and must not displace or diminish the need for an initial screening examination. *The history, physical examination, and routine laboratory examination will always b needed.* The content of the screening examination, especially routine laboratory testing, will change over t years ahead, but the screening conce will remain intact for the following reasons. There will probably never b a machine that can assess the personality of a patient and make pla to fit the emotions of the patient. Technology may, in hundreds of years, substitute for the history or physical examination but, at the moment, the time when such might occur is not in sight. At the same time, we must not fail to appreciate the limitations of the history, physica examination, and routine laboratory examination. Witness the change in our approach to coronary disease that occurred after coronary arteriography and coronary surgery became available.

Prior to the coronary arteriographic era, the diagnosis of angina pectoris was determined by the skill and reputation of the physician who said the patient had the condition. After

oronary arteriography became vailable, it became obvious that even ıe best physicians were wrong about 5 percent of the time. We soon :arned, too, that we could not etermine the prognosis of a patient /ith angina without the data supplied y high technology. The point I am ıaking, however, is that we not iscontinue our effort to improve our :reening ability just because we iscover it has limitations. After all, /e do not request coronary rteriography before we examine the atient.

I believe the results of the screening xamination should guide the hysician to use technology more cientifically and economically. houghtful physicians collect data sing the screening examination. They tudy the results of such an xamination and determine what ıould be pursued. They formulate ertain questions that should be nswered, because they believe the nswers might be of some diagnostic r therapeutic benefit to the patient. hey then choose the technique that is kely to answer the carefully ɔrmulated question. In today's ınguage we say — use the technology /hich yields an answer that has a high redictive value. In other words, the esults of a screening examination ıould guide the physician's use of igh technology. The better physicians are at screening, the wiser they are in the use of technology.

- As more diagnostic and therapeutic technology becomes available, physicians must make more decisions regarding the wisdom of using the technology in patients who have many serious health problems.

> ***"As more technology becomes available, physicians must develop a judgment that distinguishes between what* could *be done and what* should *be done in patients who have multiple serious disorders."***

The population of patients is older, and patients have multiple disorders. Although a diagnostic strategy and therapeutic technique may be available for one of the disorders, it does not follow that it is wise to proceed with the procedure when the patient is deteriorating from other problems. Although a lot *could* be done for many problems, the question is — *should* anything be done? That will be the question facing us in the future even more than it is now. It's the difference in *could* and *should*.

- There is much talk that high technology has decreased the humaneness of physicians. I do not subscribe to such a view. Is the person who is riding in an automobile less humane than one who is walking? The field of physics is cold and impersonal, but does it follow that the physicist must be cold and impersonal? Is a physician who uses technology to make a life-saving diagnosis that could not be made otherwise less humane than one who cannot make the diagnosis without the technology. I believe machines just sit there and do not in themselves create good or harm. They are neutral. Physicians must continue their personal interest and concern in patients and must not permit machines, valuable as they are in giving us new diagnostic and therapeutic methods, to displace the role of the physician as the patient's advocate. Then, too, a machine cannot comfort, give hope, or talk about the excitement of the future.

**Conclusions**

Cardiovascular medicine has progressed to its current state because of modern technology. It is easy to predict that future diagnostic and

therapeutic advances will also occur because of technologic advances.

In the future, the profession should not conclude that the initial screening examination must not be maintained and perfected, because it is the results of this examination that guides us to use technology wisely.

As more technology becomes available, physicians must develop a judgment that distinguishes between what *could* be done and what *should* be done in patients who have multiple serious disorders.

Finally, and equally important, we in the profession must not abdicate our role as the patient's concerned advocate to machines — valuable as they are now and will be in the future.

My bet is that cardiovascular medicine in Georgia will continue to develop. That patient care will continue to be delivered by knowledgeable physicians, using the most modern technology, and that the physicians will dominate and control the machines and procedures as they treat their patients with kindness, respect, and hope.

*J. Willis Hurst, M.D.*
*Candler Professor of Medicine (Cardiology)*
*Emory University School of Medicine*
*Chief of Cardiology, Emory University Hospital and Emory Clinic, Atlanta*

ONE-FOURTH OF ALL AMERICANS WHO HAVE HEART ATTACKS DIE QUIETLY.

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# 'Ask Not What . . . ."

I WAS STRUCK by Dr. James Kaufmann's editorial in the December *Journal,* "What MAG is Doing For Tort Reform." Dr. Kaufmann outlines the enormous efforts and energy of MAG to represent the physicians of Georgia in a thorough and expert manner and to provide some of the very best legislative representation in the United States. He touched on the corollary: what can you, the physician, do for yourself? I would like to take a few moments of your time, not to chastise but to encourage, not to point a finger but to provide suggestions as to what you, the physicians of Georgia, can and must do for your profession to continue to survive in the ever changing atmosphere of medical care delivery.

To begin with, write down the issues facing Georgia physicians. List the possible actions that you could take to contribute to your own welfare. Educate yourself on the issues: read the paper as well as the MAG Legislative Update. Communicate with your hospital and medical society officers to become more informed and more involved with joint activities.

Having educated yourself, now educate others. The place to begin is with your office staff. Call an office meeting and spend a half-hour explaining those issues that are impacting not only on you but also on your staff. Educate them about the policies and positions you feel are most appropriate. Explain how they might best help to support your positions. Enlist their help in your efforts.

With respect to your community, be visible, talk to your friends and neighbors, take the time to go to an extra meeting of a civic association or your church group and talk about the issues affecting medicine. Don't be embarrassed! People who know you respect you and want to know your feelings and your opinions. Don't be afraid to ask them to call and write influential people. Remember, the issues that affect you affect the community in general. With your help, as the community becomes more informed, it too will take action.

***"I would like to take a few moments of your time not to chastise but to encourage, not to point a finger but to provide suggestions. . . ."***

When was the last time you talked to a patient to discuss their perceptions and to explain the issues as you see them? Your patients respect you and will listen to you. Are your patients receiving the Tort Reform literature that MAG sent you? Are you providing reading material in your waiting and examining rooms that will help to educate your patients on the issues?

Communicate with your community leaders, your county commissioners, your mayors, president of your banks, president of the Chamber of Commerce, and other civic organizations. This is a time not to be shy — be bold! This is a time to communicate with those whom you know and to ask for their support.

Having accomplished the above, you have now created an army, a group of people who will take up arms in your behalf. You are now ready to close the deal, and the deal-maker is your legislator. He or she is the person who is capable of affecting change and by affecting change, affecting your life and the atmosphere in which you practice. Contact your state legislators by phone, in writing, or by taking them to lunch. Contact them by becoming active in MAG's Physician Involvement Program (PIP). Treat them with respect but communicate with them. Treat them with honesty, but educate them. Treat them as people with intelligence who must weigh all sides of an issue, but encourage them. Treat them as you would want to be treated, but communicate with them — TODAY!

The issue before us is Tort Reform. By the time you have read this, the current Tort Reform legislation will

***"Are your patients receiving the Tort Reform literature that MAG sent you? Are you providing reading material in your waiting and examining rooms that will help to educate your patients on the issues (affecting the practice of medicine)?"***

already be on the floor of the Legislature. It may have already been decided. Your support of this legislation is imperative to its passage, but remember that there are more than 40 other medically-related bills before the Legislature this Session. These bills also need your attention and your continued support and involvement.

The above prescription may require some effort and time, but please remember that there are also national issues involving Medicare and DRG reimbursement before the U.S. Congress that require your immediate attention. Rep. Roy Rowland addresses these subjects in another editorial in this *Journal*. As Rep. Rowland stresses, Congressmen need your input now in order to resolve these two very important issues that could dramatically and forever change the way in which you practice.

Your medical society can go just so far in solving your problems. The time has come, as always, for those most affected to stand up and take arms. I am sure that we all remember President Kennedy's admonition to the citizens of the United States in his Inaugural Address, "Ask not what. . . ." I ask you to use the assets before you and the time that is available to you during this legislative session to come forth and be an active part in the process.

*Richard W. Cohen, M.D.*
*Orthopedic Surgeon, Austell*
*Chairman, MAG Committee on Non-Physician Health Care Providers*
*Chairman, MAG IPA/HMO Study Committee*
*Alternate Director, MAG Board of Directors*

# *Comments on Infant Mortality*

INFANT MORTALITY rates are frequently a source of discussion because definitions of "birth" vary from one state to another and because obstetric textbooks usually define "birth" as a fetus weighing greater than or equal to 500 grams and define a fetus of less than 500 grams as an abortion. Few obstetricians consider a fetus of less than 500 grams as a birth.

***"The financial and emotional costs related to the way a physician deals with these definitions (of abortus vs. neonate) and completes or does not complete vital record certificates leads to inaccurate or absent reporting in many instances."***

Problems arise when a fetus of less than 500 grams shows signs of life at birth, and a live birth and death certificate are required. Hospitals may require a release for a "body" whenever a death certificate is completed. This may precipitate costly funeral home arrangements for an abortus of 450 grams or a neonate of 550 grams. Most hospitals are willing to deal with these problems in accordance with family wishes and dispose of fetal and neonatal remain or release them to funeral homes. Some hospitals require physicians to complete a fetal death certificate whenever any placental tissue is identified grossly or chorionic villi a seen on microscopic sections even when no fetus or fetal tissue was see or identified.

The financial and emotional costs related to the way a physician deals with these definitions and completes does not complete vital record certificates leads to inaccurate or absent reporting in many instances.

In their article elsewhere in this *Journal*, Dr. Samuels and Mr. Lavo document for us that although infant mortality rates decrease when less th 500 gram fetuses are removed from statistics, the infant mortality rate in Georgia is still high, among the wor in the nation, and that the comparati standings with other states and between health districts within our state show little change.

*Luella M. Klein, M.D.*
*Director, Maternal and Infa Health Care Project, Grady Memorial Hospital, Atlanta.*
*Chairman, MAG Committee o Maternal and Infant Health*

# New DRG Proposal Expanded to Physicians?

N THEIR EFFORTS to deal with the udget deficit, President Reagan and ongress have been unwittingly agging the country closer toward a ationalized health system.

I do not believe either the White ouse or most members of Congress ally want government control over edicine. They recognize a British-pe health system is overwhelmingly ostly and ill serves patients. evertheless, the deficit has driven us that direction.

The latest indication of this trend is e Administration's proposal to bring diologists, anesthesiologists, and athologists under the DRG payment stem. If Health and Human Services ecretary Otis R. Bowen had not tervened, the Administration would ave included all physicians in this ear's proposal. You can bet this will e the next step if Congress approves e Administration's plan for hospital-ased physicians.

Congress established prospective ayments under the DRG classification stem in 1983 as part of the Social ecurity Reform Act, limiting it to patient hospital services. The urpose back then was to bring edicare costs down and help relieve e deficit.

Deficit reduction is still tne dministration's only real justification r espousing the DRG system. It ertainly cannot be justified from an eological point of view. Imposing ghter government control over ysician care is clearly out of step ith principles such as deregulation d private initiative which the Reagan Revolution'' is supposed to ampion.

In my view, this year's DRG proposal is questionable even from the standpoint of deficit reduction. It would only save about $10 million for the next fiscal year, according to the Administration's own estimate. This is a miniscule amount relative to deficits in the $100 billion to $200 billion range. It's true the Administration believes the savings would steadily increase, reaching an estimated $290 million by fiscal 1992, but this would still be minimal compared to the size of the deficits. No one seems to know how much could be saved by bringing all physicians under DRGs, but even that amount would be relatively insignificant when compared to the problems it would cause.

Such a development would undermine the traditional role of the physician as patient advocate by eliminating the checks and balances inherent in the existing Medicare payment system, in which physicians and hospitals are paid separately. It would intensify concerns already associated with the DRG system, such as inappropriate early discharges and limitations on services. It would create an administrative nightmare. And it would take us a step closer to the British model.

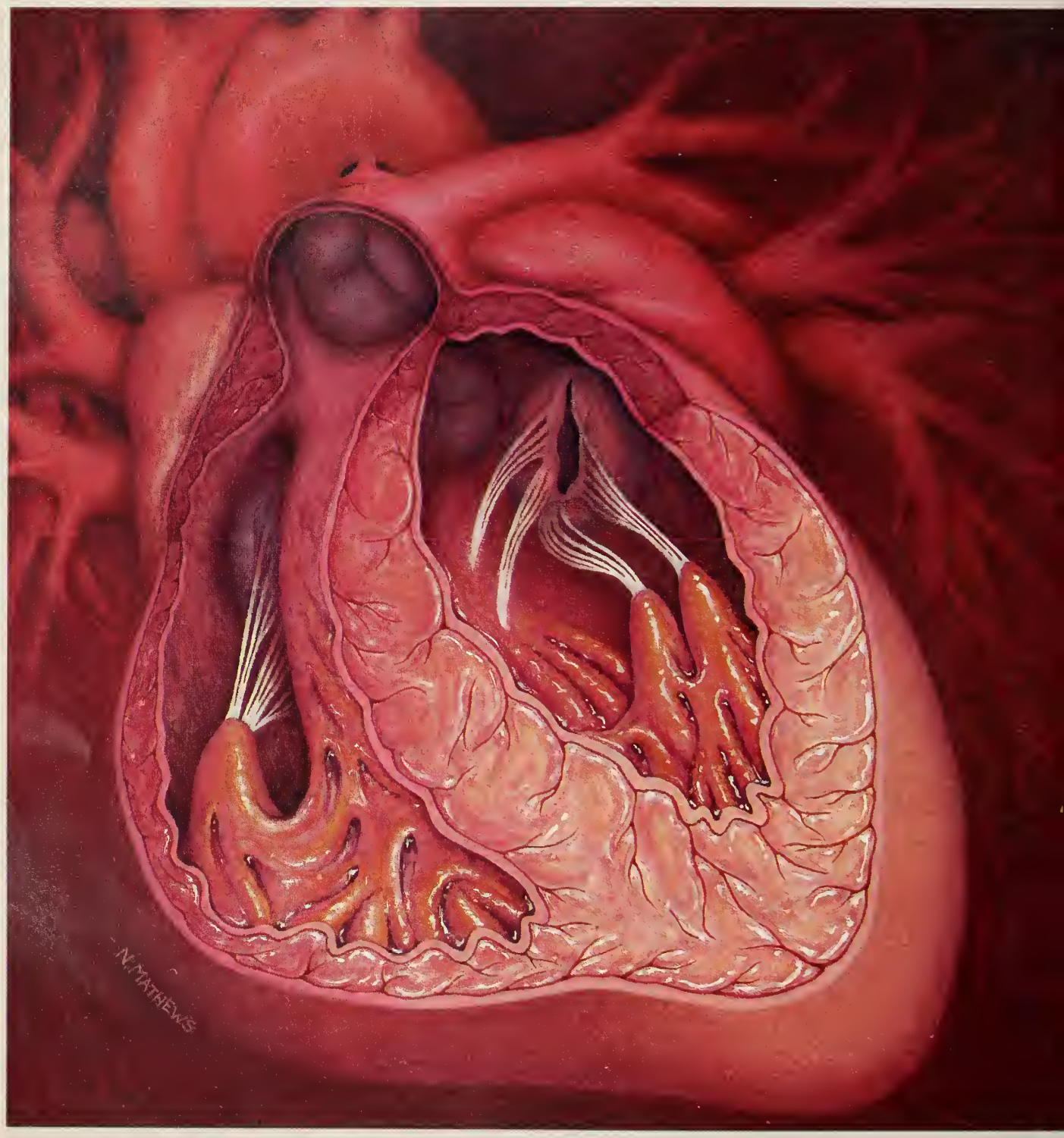
Washington needs to take decisive action to reduce health costs without sacrificing the quality of care and to bring spending more in line with revenue. But the President and Congress also need to be much more circumspect in considering new health programs, carrying out more thorough studies, and relying more on prototype programs. In our desperation to find every possible dollar to cut, we should be careful not to make hasty moves which may do more harm than good.

This is essentially what happened in 1972 when a fee freeze was imposed on physicians for 30 months, something which ended up costing more than it saved. It also happened in 1974 with the passage of the National Health Planning and Resources Development Act which established an approval system for hospital expansion, a measure which had to finally be repealed last year. Now it seems to be happening again.

President Reagan and his budget advisors do not have to tamper with the DRG system to find another $10 million for budget reduction. There are other options. Although I support a strong defense, I have little doubt this amount could be taken from the $7.7 billion increase which the Administration is seeking for the military without doing any substantial damage. For Medicare and Medicaid, incidentally, the Administration is asking for cuts totaling $6.5 billion.

A coalition of about 40 House members is already organizing in opposition to the DRG proposal. At the request of others in the group, I will be taking the lead in this fight. I urge physicians and other citizens in Georgia and across the country who share our concern to let the President and members of Congress know how they feel. With this kind of support, it is a fight I am convinced we can win.

*U.S. Rep. J. Roy Rowland*
*Washington, D.C.*


N. MATHEWS

# Heart Month: A Look at Activities of the Georgia Affiliate

D. Scott MacLeod, M.D.

FEBRUARY IS Heart Month, when American Heart Association volunteers in Georgia and throughout the nation mobilize to share information on the prevention and treatment of cardiovascular disease and receive contributions for research, education, and community programs in the fight against the nation's number one killer.

Heart attack, stroke, and other diseases of the heart and blood vessels kill almost as many people in the United States each year as all other causes of death combined. More than 53 million Americans have one or more forms of heart or blood vessel disease, and almost a million Americans will die this year from cardiovascular disease. This will include more than 22,000 Georgians.

Americans are increasingly health conscious, however, and as a result of lifestyle changes and medical and surgical advances, the heart disease death rate has declined 32.5% since 1972. Declines by specific type of cardiovascular disease from 1972 to 1984 are as follows:

| | |
|---|---|
| Coronary Heart Disease | −33.9% |
| Stroke | −47.8% |
| Hypertensive Disease | −45.7% |
| Rheumatic Fever & Rheumatic Heart Disease | −47.4% |

In the past 2 decades, millions of Americans have learned about the risk factors of heart attack and stroke and have tried to modify them favorably by seeking medical attention and by changing the way they live. Many adults have stopped smoking. The medical control of high blood pressure has greatly improved. The average cholesterol level has decreased over the past 20 years, probably due to changes in dietary habits and increased exercise.

### 1987 Campaign Goals

The 1987 campaign goal of the Georgia Affiliate of the American Heart Association is $3,161,000. Dr. Randall H. Minor, president emeritus of Shorter College in Rome, is State Heart Fund Chairman. J. Neal Purcell, managing partner of Peat, Marwick, Mitchell and Co., certified public accountants in Atlanta, is State Heart Fund Chairman-elect.

Volunteers will be active in these campaign divisions: commerce, industry, and finance; general business; special gifts; residential; clubs and organizations; professional; government; education; and special events. Among the special events will be Rock 'n' Roll-a-Thon for Heart, sponsored by the Georgia Health Care Association and its member nursing homes; Dance for Heart, an aerobic dance event sponsored by the International Dance Exercise Association (IDEA); and Jump Rope for Heart, sponsored by the Georgia Association for Health, Physical Education, Recreation and Dance (GAHPERD), with participation by boys and girls in schools throughout the state.

During the 1986-87 fiscal year, heart volunteers will check the blood pressures of 295,000 Georgians; prepare instructors to teach CPR (cardiopulmonary resuscitation); help business and industry offer the new "Heart At Work" risk reduction program to their employees; provide heart health education for youngsters in pre-school through 12th grade; and encourage Georgians to know the signals and actions for heart attack survival.

Heart Month provides an opportunity for Heart Association

Dr. MacLeod is a cardiologist with the Harbin Clinic in Rome, and President of the American Heart Association, Georgia Affiliate. Send reprint requests to Mary Johnson, Amer. Heart Assoc., Ga. Affiliate, P.O. Box 6997, Marietta, GA 30065.

This paper was sponsored by the Georgia Affiliate of the American Heart Association. Others wishing to contribute papers to this Section should contact Wesley Covitz, M.D., HEART Section Editor, and Professor of Pediatrics, Section of Pediatric Cardiology, Medical College of Georgia, Augusta, GA 30912.

*CLOSE-UP OF RESEARCH — Gerald O. Carrier, Ph.D., professor of pharmacology and toxicology at the Medical College of Georgia, explains an experiment in the relationship between diabetes and heart disease to a group of American Heart Association volunteers. The tour of "heart research in action" was a popular event during the Georgia Affiliate's Annual Meeting in Augusta.*

volunteers to offer a valuable service to the people of Georgia. As volunteers contact individuals and businesses in the 1987 Heart Fund campaign, they will give them a wallet-size Heart Card which lists the warning signals of heart attack and tells them what to do if a heart attack occurs. The Heart Card contains space for emergency phone numbers, making it easier for a heart attack victim to get immediate medical care.

**Cardiovascular Research Efforts**

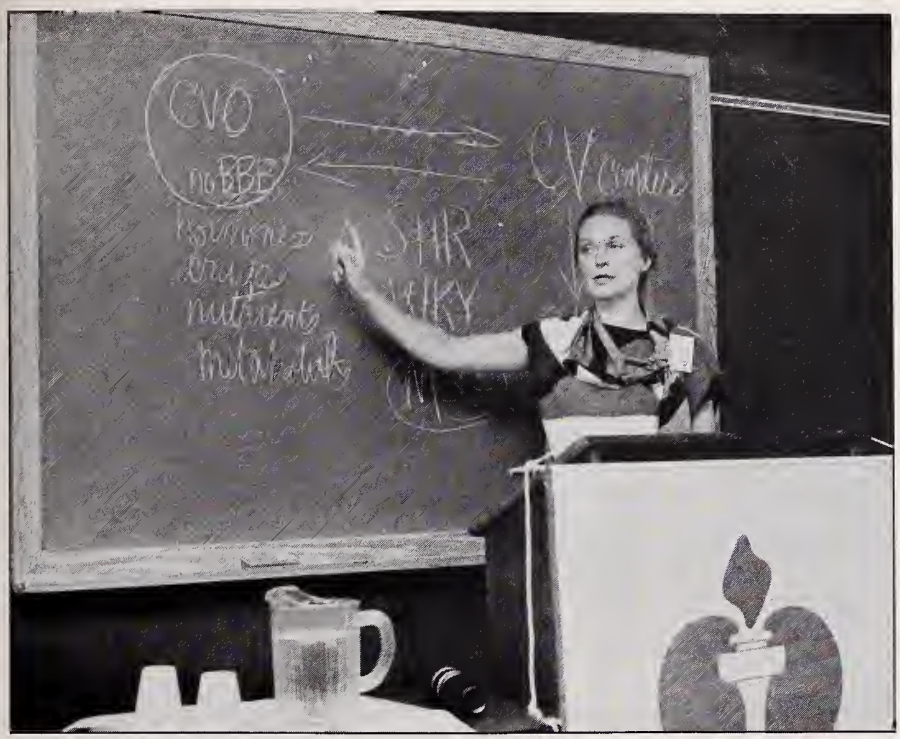
Cardiovascular research is the Heart Association's top priority in the prevention and treatment of heart disease and stroke. During 1986-87, the Georgia Affiliate is investing a total of $966,615 in cardiovascular research. This includes $475,085 for investigatorships and grants-in-aid through the Affiliate's research program and $491,530 for AHA's national research program. The Georgia Affiliate is proud of its long-standing commitment to research and is investing almost four times as much in research dollars this year as 10 years ago.

Georgia scientists, with support from the Heart Association, are studying:

- What causes blood pressure to go up and stay up.
- Why 25,000 babies each year are born with heart defects.
- The design and performance of artificial heart valves.

Three Georgia scientists have been selected as AHA Established Investigators and are receiving funding through AHA's national research program. They are Robert E. Godt, Ph.D.; Margaret L. Kirby, Ph.D.; and John Catravas, Ph.D., all of the Medical College of Georgia. Three others are conducting their research with grants-in-aid from AHA's national research program. They are Diane K. Hartle, Ph.D. of Emory; Robert J. Adams, Ph.D. of the Medical College of Georgia; and Heath H. Herman, Ph.D. of Georgia Tech.

Two scientists are continuing as Georgia Affiliate Investigators for a 3-year period through June 1987. They are Ina C. Ehrhart, Ph.D., of the Medical College of Georgia, and



*RESEARCH SYMPOSIUM — Diane K. Hartle, Ph.D. of Emory University, an Established Investigator for the Georgia Affiliate of the American Heart Association, discusses her work on hypertension at the first Cardiovascular Research Symposium in Athens last August. The symposium, co-sponsored by the Heart Association and the University of Georgia School of Pharmacy, brought together 80 Georgians from the medical and research fields to discuss scientific investigation taking place in the state. Dr. Hartle is chairman of the Georgia Affiliate's Research Peer Review Committee.*

)iane K. Hartle, Ph.D., of Emory. In ddition, the Affiliate is funding 20 -year grants-in-aid at five institutions ı Georgia, including Emory, the Medical College of Georgia, Georgia 'ech, the University of Georgia, and Mercer University.

**Community Service Programs**

When scientists find new ways to ombat heart attacks and stroke, the nowledge is put to work by Heart olunteers at the local level in the orm of Community Service Programs. 'he newest of these is "Heart At Vork," a program which makes it ossible for business and industry to ffer their employees information and ctivities in five specific areas of risk eduction: high blood pressure, moking cessation, nutrition and veight control, exercise, and signals ınd actions for heart attack survival.

Each new generation of Georgians needs to learn how to have a healthy heart. The first step is the new Heart Treasure Chest, a replica of a real pirate's chest containing games and activities to teach 4-to-7-year-olds about their hearts. The Georgia Affiliate also offers resource materials for kindergarten through fifth grade; the award-winning "3 R's and HBP" for fifth and sixth grades; a comprehensive curriculum titled "Risk Reduction: It's the Name of the Game" for seventh graders; "Let's Talk About Smoking" for grades 6-8; and CPR training for grades 9-12.

To help youngsters "eat to their hearts' content," the Georgia Affiliate co-sponsors a number of activities with the Georgia Department of Education and the Georgia School Food Service Association. These activities include School Nutrition Heart Week, which will be observed in schools throughout Georgia the week of February 9-13; a statewide conference on risk reduction; and workshops for local school lunch managers and employees.

Georgia's incidence of high blood pressure is extremely high, contributing to a large number of deaths in the state each year from stroke, heart attack, heart failure, and kidney failure. While researchers study the causes of the "silent killer" and develop new drugs for its treatment, Heart volunteers check the pressures of fellow Georgians and urge those with high blood pressure to bring it under control. Governor Joe Frank Harris proclaims High Blood Pressure Month, making the month of May the focal point for public education and screening; religious leaders request Georgia Affiliate guidelines for a church-based blood pressure program; the public orders "There's No Place Like Home for Blood Pressure Monitoring," a self-help booklet; and Georgia physicians and nurses receive educational programs on blood pressure control through their local hospital staff meetings and schools of nursing.

The emergency technique of CPR is saving lives daily in Georgia. The goal of the Georgia Affiliate is to train and certify one Instructor for every 3,200 Georgians and one Instructor-Trainer for every 13,500 residents. Changes that simplify and standardize the teaching of CPR were adopted nationally in 1986, and CPR Instructors in Georgia are among thousands of Instructors nationwide who began using the updated guidelines.

Many Georgians are making lifestyle changes as they control their blood pressure, avoid cigarettes, eat wisely, and exercise regularly. The Heart Association is helping them by providing information on risk reduction and heart attack survival through speeches and audiovisual presentations to clubs, organizations, and the general public; exhibits at health fairs and other high-traffic

locations; newspapers, magazines, radio, TV, billboards and marquees; and printed materials distributed in person during the Heart Fund campaign and at other times during the year.

### Nutrition Activities

American Heart's Food Festival, a new nationwide event for the Heart Association in cooperation with grocery stores such as A & P, BI-LO, Kroger, Piggly Wiggly Southern, and Winn-Dixie, makes it possible for Heart volunteers to distribute leaflets, posters, stickers and other materials with the theme, "It's High Time to Lower Cholesterol." The event takes place in September each year.

Other nutrition activities include a guide to "Dining Out in Atlanta," a directory of 75 restaurants that will respond to the needs of diners who are following the American Heart Association dietary guidelines, and the Culinary Hearts Kitchen Course, designed for men and women who have had a heart attack or surgery as well as those who are trying to prevent heart disease.

The American Heart Association recently announced a revision to its "Dietary Guidelines for Healthy Americans" based on the most current evidence about diet and heart health. The revised statement provides more specific guidelines on sodium, cholesterol, alcohol, and saturated fat.

*BASKET OF HEALTH — Sabrina Kuhn, R.D., vice chairman of the Nutrition Committee of the Georgia Affiliate of the American Heart Association, presents Gov. Joe Frank Harris with a basket of fresh fruit as he proclaims American Heart's Food Festival Week in Georgia.*

### Professional Education Activities

Physicians, nurses, dietitians and nutritionists, and other health professionals can depend on the Heart Association for up-to-date information that they can put to good use in taking care of their patients. Here are some of the professional education activities of the Georgia Affiliate:

- The Affiliate's Advanced Cardiac Life Support (ACLS) program continues to grow. A total of 6,516 ACLS Providers are active and 800 Instructors are certified and teaching ACLS to Georgia physicians who wa to be prepared for life-or-death heart attack emergencies.
- Cardiology Conferences for Nurses are held in several cities in Georgia each year, and Two Days of Cardiology for Nurses is an advance course which concentrated last year better nursing care for heart transplar patients.
- Medical and health professionals educators, and business leaders attended Georgia's First Conference Smoking or Health, co-sponsored in the spring of 1986 by the Georgia

***"Cardiovascular research is the Heart Association's top priority in the prevention and treatment of heart disease and stroke. During 1986-87, the Georgia Affiliate is investing a total of $966,615 in cardiovascular research."***

Affiliate and 26 other organizations. U.S. Surgeon General C. Everett Koop was the keynote speaker as the audience learned how to develop smokefree environments at hospitals, schools, worksites, and public places.

- The Affiliate helps Georgia hospitals establish cardiac rehabilitation programs for patients who have had a heart attack or heart surgery and sponsors an annual workshop on cardiac rehabilitation and/or preventive cardiology.
- Physicians, scientists, and nurses may subscribe to professional publications and take advantage of other medical and scientific opportunities in the American Heart Association. Membership in the AHA Scientific Councils and participation in the annual Scientific Sessions are offered at the national level. Details are available from the Georgia Affiliate.

The American Heart Association relies on contributions from the public to support cardiovascular research, conduct community service programs, train health professionals, and educate the community about heart disease. The major sources of funds are the annual Heart Fund campaign with Heart Month in February as its focal point . . . the Heart Memorial Gifts Program honoring family or friends . . . Planned Giving for long-term benefits to the donor and the Heart Association . . . and Bequests.

How can *you* help? Support the fight against heart disease by contributing generously to the annual Heart Fund campaign, using the Heart Memorial Gifts program, including the American Heart Association/Georgia Affiliate in your financial and estate plans, and being an active volunteer.

The Heart Association has an ongoing volunteer organization in most Georgia counties and local offices in 15 Georgia cities. For more information, contact your local American Heart Association or the American Heart Association/Georgia Affiliate at P.O. Box 6997, Marietta, GA 30065, phone 404/952-1316.

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# SURGICAL TREATMENT OF VARICOSE VEINS: A DOWNWARD TREND

MILTON F. BRYANT, M.D., GEORGES M. MALIHA, M.D.

*This study looks at the pattern of varicose vein surgery in four major hospitals in the metropolitan Atlanta area.*

VARICOSE VEINS are probably as old as the human race, with descriptive records dating back to Hippocrates. In the 2nd century A.D., Galen suggested tearing out the veins with a hook-like device, and it was not until the 7th century A.D. that Aeginata proposed ligation of varicosities. In the 16th century, Ambrose Paré recognized leg uclers as a complication of varicose veins and suggested the use of cauterization to obliterate "the large pools of blood." Recorded history reveals that physicians began to treat varicosities by injecting various sclerosing chemicals, circa 1835, and this modality has continued in use worldwide by innumerable physicians.[6] Numerous chemical substances have been used to thrombose varicosities, and in 1946, Sotredecol was proposed as a safer and better sclerosant. Ligation of the saphenofemoral junction was popularized by Keeler and Mayo at the beginning of the century, and subsequently, stripping of varicosities was added to the ligation technique by many surgeons.[25]

The combination of injection-compression treatment of varicosities, alone or in combination with surgery — before, during, and after — has been reported on a large series of patients successfully treated in Ireland using the injection-compression technique.[6, 25] Hobbs and others from the United Kingdom have confirmed his good results. These reports influenced the National Health Service in England to mandate this technique as the preferred method of treatment for varicose veins.

Today many surgeons worldwide continue to strip out saphenous veins in spite of the absolute need, if possible, for keeping these irreplaceable veins in one's vessel bank. In some patients, the saphenous veins, or segments of these veins, are severely diseased and dilated and not suitable for use in bypass surgery.

Varicosities, as used in this paper, denote elongation, dilatation, sacculation, and/or tortuosity of veins in the subcutaneous tissue of the lower extremities. We recognize the presence of intracutaneous varicosities, so-called spider or vanity varicosities, as an accompanying or separate problem. These blemishes will not be discussed in this report. Subcutaneous varicositites involve the greater (long) and lesser (short) saphenous veins and their many named and unnamed tributaries. After reviewing these 512 records, we feel all the patients described in this report had primary and not secondary varicosities.

Dr. Bryant is a vascular surgeon, and Dr. Maliha is a senior medical student at Morehouse School of Medicine, Atlanta. Send reprint requests to Dr. Bryant at 3569 Dumbarton Rd., Atlanta, GA 30327.

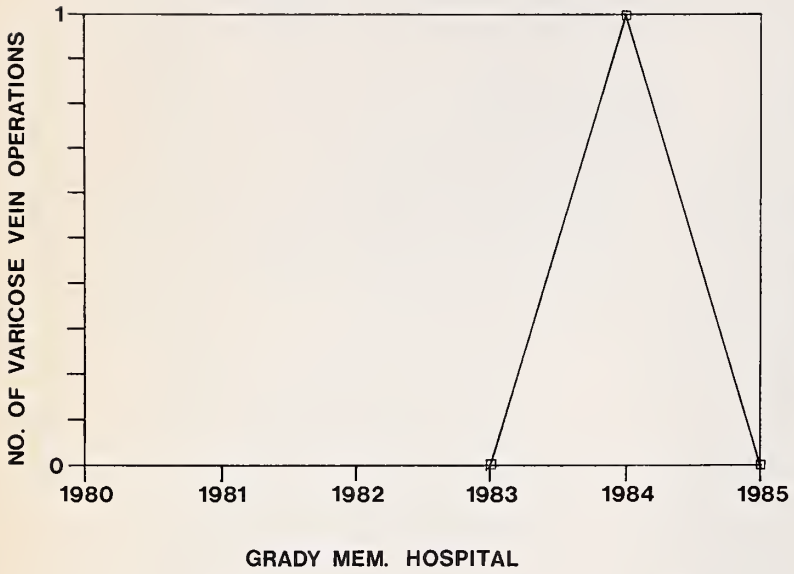



*Figure 1 — Number of varicose vein operations performed at Grady Memorial Hospital, 1980-1985, Atlanta, Georgia.*

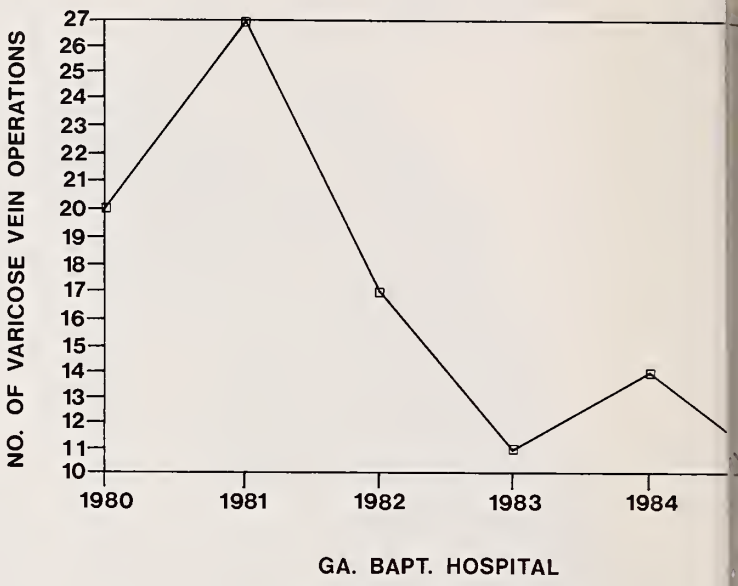


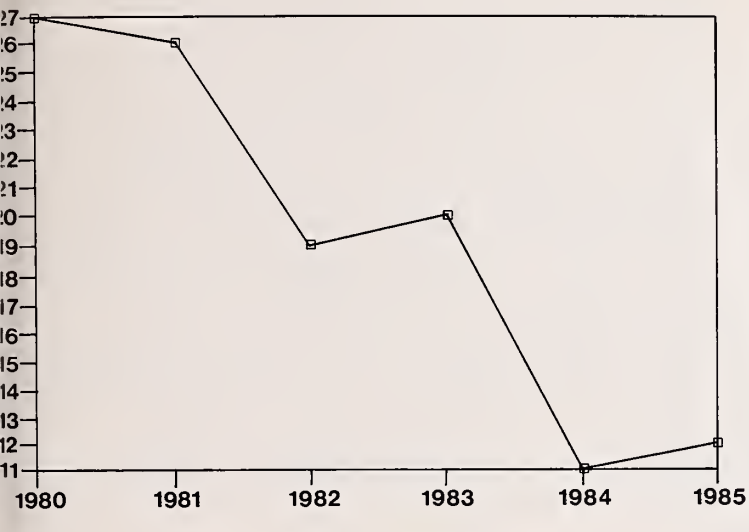

*Figure 2 — Number of varicose vein operations performed a Georgia Baptist Hospital, 1980-1985, Atlanta, Georgia.*

Varicose veins are a common ailment of humans.[19, 24] It is estimated that 20% of women and 7% of men above the age of 30 or 40 will develop varicose veins. The incidence of females to males is approximately 4:1.[13, 25] Many patients with large varicosities are symptom free. Complaints may be unrelated to the size of the dilated veins. Excessive tiredness with standing, aching, bursting, burning, itching, cramping, pain of many descriptions, and cosmetic repulsiveness are some of the complaints voiced by patients.

***"Since World War II, most surgeons and physicians have developed conservative attitudes toward any method — sclerosing or surgical — that interferes with the integrity of the saphenous veins."***

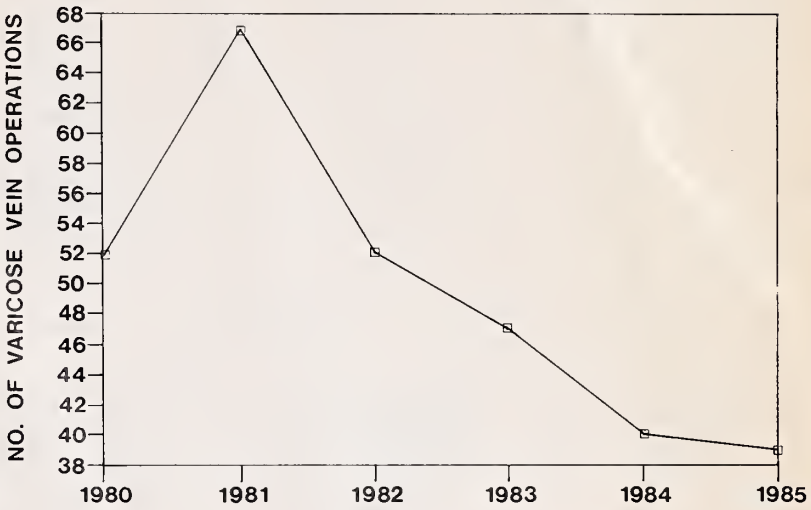
Patients use different terms to describe their concerns and their problems. More serious problems associated with primary varicosities, such as leg ulcerations, vein rupture, acute bland thrombosis, superficial thrombophlebitis and pulmonary embolization, may occur and have been reported. Most surgeons, however, agree that these complications are uncommon.[7, 19, 25]

The treatment of varicose veins can be divided into five categories: 1. Education and assurance, 2. Elastic supports, 3. Injection-compression, 4. Surgery-ligation and stripping, 5. Various combinations of these modalities. Sweeping statements from various physicians and surgeons about the effectiveness of one method of treatment versus the other are described abundantly in the medical and lay literature. Some examples include: "all varicosities can be treated by injection, provided compression bandages can be applied and kept in position for an adequate time"; "the stripping operation advocated in the treatment of varicose veins is questioned by the findings"[24]; "the probability of having no further treatment is significantly greater than those treated surgically"[2]; "one quarter of patients found support hose sufficiently acceptable that they decided not to undergo surgery"[4]; "the risk of treatment in a non-fatal disorder has to be taken into account when the choice of treatment is made because many patients who ask for treatment do not need it"[2]; and, "at the present time, there is no evidence that one form of treatment is better than the other."[3] An attempt to assess and compare the different forms of treatment is not the purpose of this report.




S. FULTON HOSPITAL

*Figure 3 — Number of varicose vein operations performed at South Fulton Hospital, 1980-1985, Atlanta, Georgia.*




PIEDMONT HOSPITAL

*Figure 4 — Number of varicose vein operations performed at Piedmont Hospital, 1980-1985, Atlanta, Georgia.*

Despite efforts at classification and definition of varicosities, the concept encompasses so many different patterns that comparison becomes difficult and, at times, an exercise in futility. The period of follow-up, the rich diversity of the superficial venous pattern, the expertise and interest of the surgeon or physician treating the patients, and other innumerable factors led us to conclude that even a fair degree of certainty regarding comparison of varicose vein treatment methods is impossible.[12, 24]

With the rapid development of cardiac and arterial vascular surgery following World War II, most surgeons and physicians have developed conservative attitudes toward any method — sclerosing or surgical — that interferes with the integrity of the saphenous veins. All physicians realize the long and short saphenous veins are invaluable graft material and should be preserved.[1, 15, 22] This study looks at the pattern of varicose vein surgery in four major hospitals in the metropolitan Atlanta area.

## Material and Methods

Records of all varicose vein stripping operations performed at Grady Memorial Hospital, Georgia Baptist Hospital, Piedmont Hospital, and South Fulton Hospital between 1980 and 1985 were reviewed. Stripping procedures involving the greater or lesser saphenous veins were plotted on graphs, Figures 1-5. The following data were analyzed retrospectively: sex, age, complications, length of hospitalization.

## Results

The ratio of surgical admissions compared with the number of patients having at least one saphenous vein totally removed was calculated: Grady Memorial Hospital was 0.0019% (Figure 1); Georgia Baptist Hospital, 0.19% (Figure 2); South Fulton Hospital, 0.316% (Figure 3); and Piedmont Hospital, 0.646% (Figure 4). If the total number of stripping operations performed at these four community hospitals is plotted on a composite graph, one notes an unmistakable trend toward performing less saphenous vein stripping procedures in 1985 as compared with 1980 (Figure 5). The sex and age population was consistent with reports in literature (M/F:3.5:1); and the average age was 47.[12, 16] No mortality and no serious morbidity were reported in these 512 patients. Postoperative hematomas comprised the great majority of complications described in the patient's records. No serious infections were reported, and no patient developed a recognizable pulmonary embolism or thrombosis in the deep venous system. The average period of

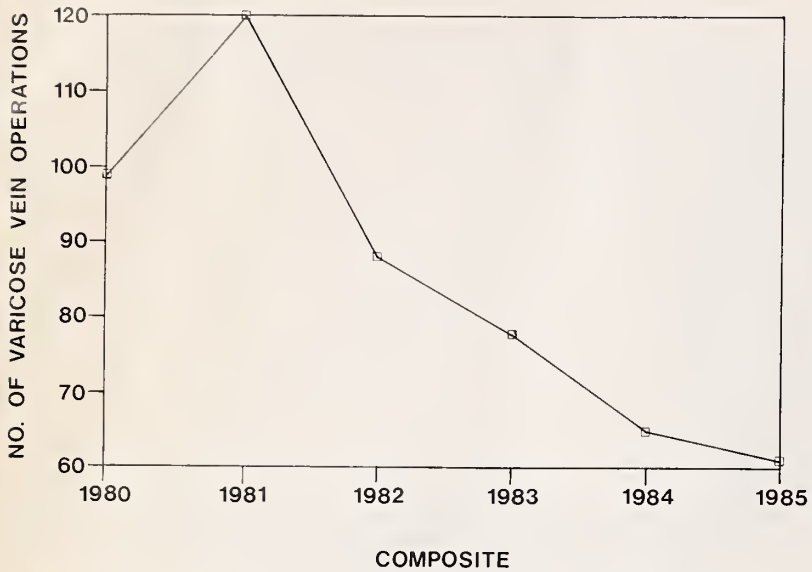



*Figure 5 — Number of varicose vein operations performed at four community hospitals, 1980-1985, Atlanta, Georgia.*

hospitalization was 3 days, and the estimated total hospital cost was approximately $3,000 per person.

It was impossible to determine other economic losses such as absence from work and disruption with loss of income by others who helped with the patient's postoperative care. Information regarding money paid to baby sitters, the cost of various medications, or the knowledge of the surgeon's fee was not available.

An effort was made to determine why there was such a large variation in the number of saphenous stripping procedures performed at these four community hospitals. Demographics of the hospital population, values and attitudes of the patients, referring physicians and surgeons performing the operations, and other factors were considered. Unfortunately, we could establish no facts and concluded that speculation should be omitted, left to philosophers, and not included as a possible scientific fact.

## Conclusion

The number of saphenous vein ligation and stripping procedures performed for primary varicose veins at Grady Memorial Hospital, South Fulton Hospital, Georgia Baptist Hospital and Piedmont Hospital totalled 512, and the results are reported in a retrospective fashion. It is noted that only one saphenous vein stripping operation was performed at Grady Memorial Hospital during the period 1980-1985. It is apparent that most surgeons working in these four Atlanta hospitals are trying to limit the number of varicose vein operations. However, the fact remains that 512 patients have lost their saphenous veins (40% were bilateral), and if these patients need this vein for a grafting procedure, a serious problem has been created. Prudent surgeons should encourage the preservation of saphenous veins. Hopefully, with the new MRI and real time ultrasonic techniques (Duplex scanning), surgeons will be able to develop better methods of preventing and treating varicose veins. With our present knowledge, we are left with an amorphous answer to the question, "When is sclerosing and/or surgical treatment necessary?"

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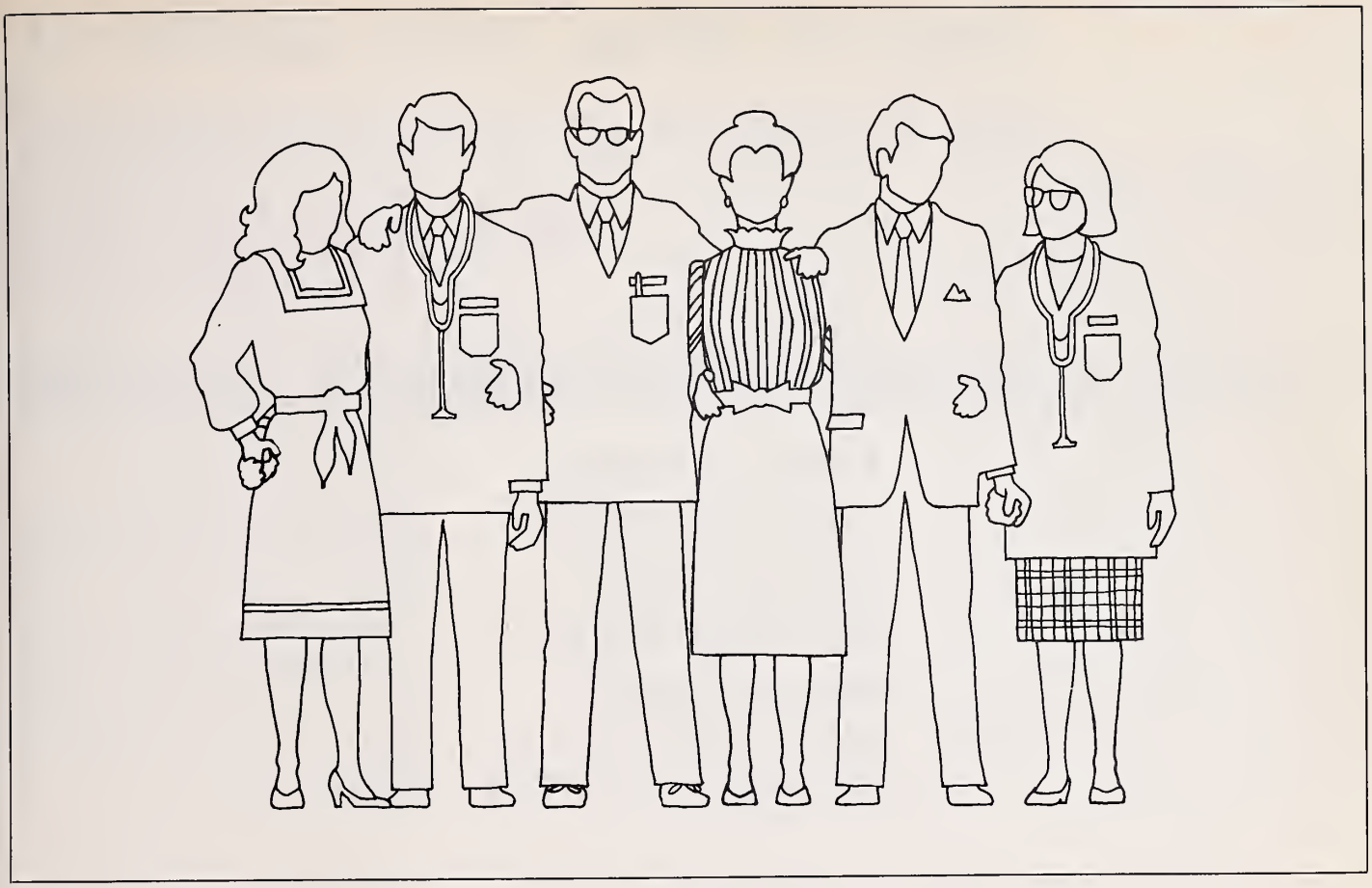


# YOU AND MALPRACTICE STRESS:

## *V. A Death in the Family*

ERNEST C. FOKES, M.D.

***Editorial Note:*** *This is the fifth in our series of articles on the emotional and physical stress which physicians experience when sued for malpractice. Here, Dr. Ernest Fokes describes how one physician, faced with a liability lawsuit, dealt — or failed to deal — with the crisis of being sued.*

*Through our Committee on Professional Liability Support Groups, MAG plans to help counsel physicians and their spouses suffering from "malpractice stress syndrome."*

On Tuesday, November 25, 1986, Dr. George F. Laszlo, a 72-year-old general practitioner in Woodbury, Long Island, New York, took his life.

In late 1984, a male patient had come to Dr. Laszlo complaining of chest pains. He was examined and advised to go to the hospital. The patient did not follow the advice, saying that he had a bridge game the next day. But the next day he had a heart attack. The patient survived and subsequently sued Dr. Laszlo, charging that the doctor had "not taken care of the condition or warned him of the severity of the situation." The case was scheduled for trial in November, 1986, but at the request of the plaintiff's attorneys, a delay was granted until January, 1987.

Dr. Fokes is a neurosurgeon. His address is 370 Winn Way, #201, Decatur, GA 30030.

Dr. Laszlo suffered a stroke 3 months ago, and according to his son, had become more and more despondent as the trial date approached. One who has not experienced a malpractice suit cannot appreciate the perceived degradation of the experience. Mr. Raymond Fury, the doctor's attorney, said, "He was having trouble understanding the way things work here, these suits are often looked at as just a part of the game in America, but it was not just a game to him."

A fellow physician observed, "The tragedy of the situation is that he was an extraordinarily intelligent man, very sensitive, and he found himself trapped in a situation that he felt was totally unfair."

It was a game. A game in a something-for-nothing society. In its most benign form, it is played on television game shows where a chance to get rich quick attracts hundreds of players, and millions of viewers will sit transfixed in front of a screen for a few minutes of vicarious pleasure.

In the absurd play *Waiting for Godot,* the two principals in the story wait endlessly beside a dead tree for Godot to come and make good times come for them. I think that sometimes they are the personification of Americans today who truly look forward to some minor or major disaster, real or perceived, to befall them and bring with it the windfall of a lifetime. At least those two characters in the play were harmless in that no one else was hurt by their passivity.

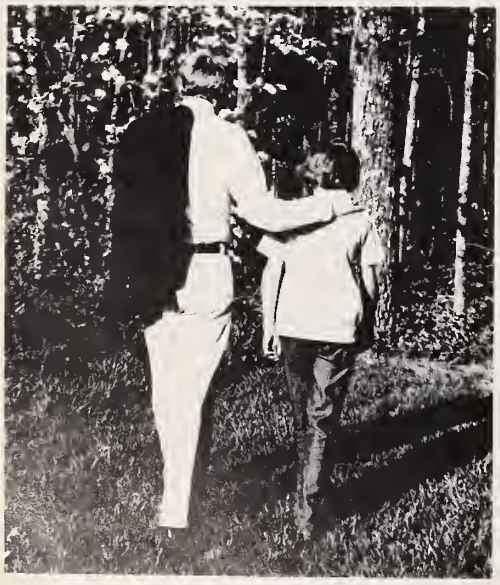
But the game goes on and is played in lotteries where the same mentality prevails: Something for nothing — or, in the main, only a dollar or two is at risk.

By gradations, the game gets worse, and the stakes grow higher. A Wall Street broker works a scam that nets millions. But that has a certain ambiguity to it: The numbers are too huge to be conceived of in "real life" and it's Wall Street and we can look at it and almost feel: "So, what else is new?" It's less personal. Besides, the investigation will last years; the trial, if it comes to that, more years; and by the time it all comes to a conclusion, both the enormity of the deed and the characters will, for the most part, have been forgotten.

***"He was having trouble understanding the way things work here, these suits are often looked at as just a part of the game in America, but it was not just a game to him."***

But then, the game becomes acutely and malignantly personal and quick. On Tuesday, November 25, 1986, a family practitioner felt so keenly dishonored and degraded by what he saw happening to himself that he killed himself. Nothing ambiguous, nothing vague, and absolutely and undeniably vivid. A man who was sensitive and intelligent is dead.


# At CPC Parkwood, Caring Comes First



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# 60,073 patients (90%) who started on INDERAL® LA stayed on INDERAL LA.[1*]

## Surprising? Not really.

**Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.**
**A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients[2] revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol—which shows how well-tolerated once-daily INDERAL LA can be.**

## Sole therapy or concomitant therapy? Fifty-nine percent of the time, INDERAL LA stood on its own.

The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were controlled merely with the addition of a diuretic to INDERAL LA.

## For the noncompliant patients in your practice, INDERAL LA may well be the answer.

Almost 20,000 of the patients in the nationwide compliance trial were identified as having been noncompliant with their previous antihypertensive therapy. Their physicians reported that 88% showed improved compliance when placed on once-daily INDERAL LA.

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LONG ACTING CAPSULES

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

# The one you know best keeps looking better

Please see next page for brief summary of prescribing information.

# The one you know best keeps looking better

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

**INDERAL® LA** brand of propranolol hydrochloride **(Long Acting Capsules)**

**DESCRIPTION.** Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

**CLINICAL PHARMACOLOGY.** INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

**INDICATIONS AND USAGE. Hypertension:** INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

**Angina Pectoris Due to Coronary Atherosclerosis:** INDERAL LA is indicated for the long-term management of patients with angina pectoris.

**Migraine:** INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

**Hypertrophic Subaortic Stenosis:** INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

**CONTRAINDICATIONS.** INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

**WARNINGS.** CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

**Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)**—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

**PRECAUTIONS.** *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

*Clinical Laboratory Tests:* Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

*Carcinogenesis, Mutagenesis, Impairment of Fertility:* Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

*Pregnancy:* Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

*Nursing Mothers:* INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

*Pediatric Use:* Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS.** Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

*Cardiovascular:* bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

*Central Nervous System:* lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

*Gastrointestinal:* nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

*Allergic:* pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

*Respiratory:* bronchospasm.

*Hematologic:* agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

*Auto-Immune:* In extremely rare instances, systemic lupus erythematosus has been reported.

*Miscellaneous:* alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

**DOSAGE AND ADMINISTRATION.** INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

**REFERENCES:**


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# THE EFFECTS OF EXCLUDING <500 GRAM INFANTS ON INFANT MORTALITY RATES IN GEORGIA

BARBARA N. SAMUELS, M.D., M.P.H., MICHAEL R. LAVOIE, M.A.

**ABSTRACT**

**Infant mortality rates (IMRs) for all 50 states and the District of Columbia are recalculated after excluding <500 gram births from 1983 vital records. Georgia experiences one of the largest infant mortality rate declines by this method, but its IMR remains one of the worst in the nation. Similar recalculations are performed for each of Georgia's 19 health districts using the 1980-1982 linked infant death file. Health districts with the worst IMRs in the state generally retain their poor standing despite the recalculation. The question is not whether to include or exclude the <500 gram birthweight category from live birth determinations, but rather to determine why these infants were born so prematurely.**

## Introduction

THE DEFINITION of a live birth in Georgia* has no lower limit for birthweight. Survival of infants with birthweights <500 grams is extremely rare at best. It is argued that Georgia's live birth definition yields an inflated state infant mortality rate (IMR) compared with other states, because births <500 grams in Georgia are counted as live births. The argument implies that Georgia is one of the minority of states that does not exclude the <500 gram birthweight category in its live birth definition. It is believed that this live birth definition also has a disproportionate impact on IMRs in Georgia's 19 health districts, particularly in urban areas with tertiary neonatal centers, where aggressive treatment can maintain some of the very tiny newborns for short periods of time. Infant mortality rates are thus elevated in these districts because of the larger number of <500 gram infants born at tertiary centers. Furthermore, the current live birth definition is thought to have an adverse effect on IMR calculations in states or health districts with large black populations because blacks are at increased risk of delivering infants with extremely low birthweights.[1]

This report attempts to address these concerns. The authors contacted vital records departments in several southeastern states and Ohio, the National Center for Health Statistics (NCHS) Vital Statistics Registration Branch Office, and the Centers for Disease Control (CDC) in Atlanta to compare Georgia's live birth definition with those in other states. To examine the effect of Georgia's live birth definition, infant mortality rates for Georgia and the rest of the United States and for Georgia's 19 health districts were calculated with and without the <500 gram category.

## State Live Birth Definitions

According to publications[2] and staff[3] of NCHS, most states use the same or similar criteria as Georgia for defining a live birth. Only Ohio has a legally defined lower limit of 20 weeks gestational age, *regardless of birthweight,* for recording live births.[2-4] Georgia's live birth definition is the same as that adopted by the World Health Organization and recommended by NCHS and the Statistical Commission of the United Nations.[3] The CDC is not using a 500

* The complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of the pregnancy, which, after such expulsion or extraction, breathes, or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles whether or not the umbilical cord has been cut or the placenta attached. (Official Code of Georgia Annotated, Vol 23, Section 31-10-1(9). The Minche Co., Charlottesville, VA, 1985.)

Dr. Samuels is a Perinatal Epidemiologist, Office of Epidemiology, Room 210, Division of Public Health, Georgia Department of Human Resources (DHR) 878 Peachtree St., Atlanta, GA 30309; and Mr. Lavoie is Director of Vital Records and Health Statistics, Division of Public Health, Georgia DHR. Send reprint requests to Dr. Samuels.

gram cutoff for most of the analyses in its National Infant Mortality Surveillance (NIMS) project.[5]

### Georgia And The U.S.

Numbers of births and infant deaths for 1983 were obtained from National vital statistics.† Assuming that all infants with birthweights <500 grams would not survive, we recalculated state IMRs by excluding the <500 gram infants from both the numerator and the denominator of the standard infant mortality rate equation:

$$\text{IMR} = \frac{\#\text{ infant deaths} - \#\text{ live births} < 500\text{ gm}}{\#\text{ live births} - \#\text{ live births} < 500\text{ gm}} \times 1000$$

States were ranked by IMRs calculated with and without the <500 gm infants. The percentage decline for each state's IMR was also calculated. Results are presented in Table. 1.

Georgia displays one of the larger reductions in IMR (14%) of any state after excluding the <500 gram birthweight infants. One-fifth of all states show IMR decreases of similar or greater magnitude than Georgia: Wisconsin, Illinois, North Carolina, Rhode Island, and Virginia (13%); Michigan (14%); Maryland (15%); Connecticut and the District of Columbia (17%); Vermont (19%); and Delaware (22%).

Georgia ranked 47th in the United States for IMR in 1983. Eliminating the <500 gram birthweight category from IMR calculations improves Georgia's ranking only two positions, to 45th. In contrast, Wisconsin improves from 12th to 8th; Rhode Island, 37th to 33rd; Michigan, 38th to 28th; Maryland, 38th to 24th; Connecticut, 21st to 8th; Vermont, 2nd to 1st; and Delaware, 18th to 2nd. Excluding births <500 grams has little effect on the position of Georgia's IMR in the U.S. while improving other states' rankings.

Thirty-five percent of Georgia's live births were black — the fourth highest percentage of black births in the U.S. during 1983 (Table 2). The large percentage of black births account, in part, for Georgia's relatively large change in IMR when <500 gram births are excluded from the calculations. Except for Alabama, all states where over 30% of live births are black (the District of Columbia, Georgia, Louisiana, Maryland, South Carolina) show greater than a 10% decline in their recalculated IMRs (Tables 1 and 2). Of the twelve states with the smallest reductions in the recalculated IMR (Alabama, Arizona, Arkansas, Idaho, Montana, Nebraska, Nevada, North Dakota, South Dakota, Utah, West Virginia, and Wyoming), all except Alabama and Arkansas have black live birth populations of five percent or smaller. However, all of the states with similar or larger changes than Georgia in their recalculated IMRs have smaller percentages of black live births than Georgia, with the exception of the District of Columbia. Blacks account for 7% or less of all live births in three of these states (Rhode Island, Vermont, and Wisconsin).

***"It is argued that Georgia's live birth definition yields an inflated state infant mortality rate (IMR) compared with other states, because births <500 grams in Georgia are counted as live births."***

Twenty-four states share or exceed Georgia's 16% decline for recalculated black IMRs (Table 3). Georgia is one of four states that share the tenth largest decrease (11%) for recalculated white IMRs (Table 4). Georgia is one of 10 states, including the District of Columbia, where the reduction in both black and white recalculated IMRs exceeds 10%. All 10 of these states exhibit declines greater than 11% in their recalculated total IMRs (Table 1). Thus, states most affected by excluding the <500 gram birthweight category in IMR calculations display large changes in both black and white IMR recalculations, regardless of the percentage of black live births.

### Georgia Health Districts

Using Georgia's Linked Infant Death Fact File (IDFF) for live births from 1980-1982,‡ IMRs with and without deaths to infants in the <500 gram birthweight category§ were calculated for each of Georgia's 19 health districts. The data are based on district of mother's *residence* at the time of birth and not on the district where the birth occurred. Because numbers of deaths by birthweight were available, calculations differed somewhat from those for the U.S. described above:

$$\text{IMR} = \frac{\#\text{ infant deaths} - \#\text{ infant deaths} < 500\text{ gm}}{\#\text{ live births} - \#\text{ infant deaths} < 500\text{ gm}} \times 1000$$

Results are presented in Table 5 and include IMRs, rankings, and the percentage decline in IMR for each district.

Excluding deaths to the <500 gram birthweight category has a greater impact on districts with urban areas (Fulton, Macon, Albany, Savannah). Three of these districts (Fulton, Macon, Savannah) have tertiary neonatal centers. However, two predominantly rural areas (Dalton, Brunswick) and one suburban district (Cobb-Douglas) also show decreases in excess of 11% after eliminating the <500 gram deaths from IMR calculations. On the other hand, Augusta, with both an urban area and a tertiary neonatal center, displays one of the better IMRs in the state with or with-

† These data were provided by the Department of Vital Statistics, National Center for Health Statistics, Hyattsville, Md.

‡ The tables were provided by the State Center for Health Statistics, Division of Public Health, Georgia Department of Human Resources, Atlanta, Georgia.

§ Not all <500 gram birthweight infants died according to the vital records. That the "survivors" may actually be unregistered or mislabelled deaths is currently under investigation.

**Table 1 — State IMRs and Rankings With and Without <500 Gram Birthweight Infants, 1983 NCHS Data**

| *State* | *IMR* | *Rank* | *IMR Minus <500 gm* | *Rank Minus <500 gm* | *% IMR Decrease* |
|---|---|---|---|---|---|
| U.S. | 11.2 | | 10.0 | | 10.7 |
| Alabama | 13.1 | 45 | 12.3 | 48 | 6.1 |
| Alaska | 12.4 | 42 | 11.4 | 43 | 8.1 |
| Arizona | 9.5 | 10 | 8.9 | 16 | 6.3 |
| Arkansas | 10.7 | 23 | 10.1 | 28 | 5.6 |
| California | 9.7 | 14 | 8.6 | 12 | 11.3 |
| Colorado | 10.0 | 18 | 9.1 | 18 | 9.0 |
| Connecticut | 10.1 | 21 | 8.4 | 8 | 16.8 |
| Delaware | 10.0 | 18 | 7.8 | 2 | 22.0 |
| Dist. Columbia | 19.3 | 51 | 16.0 | 51 | 17.1 |
| Florida | 12.2 | 41 | 10.9 | 42 | 10.7 |
| Georgia | 13.4 | 47 | 11.5 | 45 | 14.2 |
| Hawaii | 9.4 | 9 | 8.5 | 11 | 9.6 |
| Idaho | 10.8 | 26 | 10.1 | 28 | 6.5 |
| Illinois | 12.4 | 42 | 10.8 | 41 | 12.9 |
| Indiana | 11.4 | 33 | 10.3 | 37 | 9.6 |
| Iowa | 8.9 | 5 | 8.2 | 6 | 7.9 |
| Kansas | 10.3 | 22 | 9.1 | 18 | 11.7 |
| Kentucky | 11.6 | 35 | 10.5 | 39 | 9.5 |
| Louisiana | 13.5 | 48 | 11.9 | 47 | 11.9 |
| Maine | 8.7 | 2 | 7.9 | 4 | 9.2 |
| Maryland | 11.8 | 38 | 10.0 | 24 | 15.3 |
| Massachusetts | 9.1 | 8 | 8.1 | 5 | 11.0 |
| Michigan | 11.8 | 38 | 10.1 | 28 | 14.4 |
| Minnesota | 9.8 | 15 | 8.8 | 15 | 10.2 |
| Mississippi | 15.1 | 50 | 13.9 | 50 | 7.9 |
| Missouri | 10.7 | 23 | 9.6 | 23 | 10.3 |
| Montana | 9.0 | 7 | 8.7 | 14 | 3.3 |
| Nebraska | 9.9 | 17 | 9.3 | 20 | 6.1 |
| Nevada | 10.7 | 23 | 10.1 | 28 | 5.6 |
| New Hampshire | 8.6 | 1 | 7.8 | 2 | 9.3 |
| New Jersey | 11.5 | 34 | 10.2 | 33 | 11.3 |
| New Mexico | 10.0 | 18 | 9.3 | 20 | 7.0 |
| New York | 11.6 | 35 | 10.6 | 40 | 8.6 |
| North Carolina | 13.2 | 46 | 11.5 | 45 | 12.9 |
| North Dakota | 8.9 | 5 | 8.4 | 8 | 5.6 |
| Ohio | 11.2 | 31 | 10.0 | 24 | 10.7 |
| Oklahoma | 10.9 | 28 | 10.0 | 24 | 8.3 |
| Oregon | 9.6 | 12 | 8.9 | 16 | 7.3 |
| Pennsylvania | 11.3 | 32 | 10.0 | 24 | 11.5 |
| Rhode Island | 11.7 | 37 | 10.2 | 33 | 12.8 |
| South Carolina | 15.0 | 49 | 13.4 | 49 | 10.7 |
| South Dakota | 10.8 | 26 | 10.2 | 33 | 5.6 |
| Tennessee | 12.8 | 44 | 11.4 | 43 | 10.9 |
| Texas | 11.1 | 30 | 10.1 | 28 | 9.0 |
| Utah | 8.8 | 4 | 8.2 | 6 | 6.8 |
| Vermont | 8.7 | 2 | 7.1 | 1 | 18.4 |
| Virginia | 11.9 | 40 | 10.3 | 37 | 13.4 |
| Washington | 9.5 | 10 | 8.6 | 12 | 9.5 |
| West Virginia | 10.9 | 28 | 10.2 | 33 | 6.4 |
| Wisconsin | 9.6 | 12 | 8.4 | 8 | 12.5 |
| Wyoming | 9.8 | 15 | 9.4 | 22 | 4.1 |

out the <500 gram category and one of the smallest declines in IMR. Columbus, another urban center with a tertiary unit, has relatively poor IMRs regardless of the calculation used and shows only an intermediate decline for its recalculated IMR compared to other districts (Table 5).

The districts with the highest IMRs in the state (Albany, Columbus, Fulton, Dublin) still have the highest IMRs in the state after the recalculation. Only Savannah, which improves three places, from 15th to 12th, and Valdosta, which drops from 10th to 13th, change their district IMR rankings in the state by more than two positions.

Black live births (Table 6) account for at least 45% of all live births in four of the districts, with the largest declines in the recalculated IMRs (Fulton, Macon, Albany, Savannah) and 35% in a fifth district (Brunswick). Among districts with the largest IMR reductions, only Dalton has a small black live birth population (2% of all live births). Blacks account for between 33% and 48% of all live births in three (Augusta, Valdosta,

Table 2 — Percentage Black Live Births, United States, 1983

| State | Percentage of Black Live Births |
|---|---|
| U.S. | 16.1 |
| Alabama | 34.3 |
| Alaska | 4.4 |
| Arizona | 4.3 |
| Arkansas | 24.1 |
| California | 10.3 |
| Colorado | 4.9 |
| Connecticut | 12.3 |
| Delaware | 25.0 |
| Dist. Columbia | 80.1 |
| Florida | 25.1 |
| Georgia | 35.0 |
| Hawaii | 4.2 |
| Idaho | 0.5 |
| Illinois | 21.2 |
| Indiana | 10.9 |
| Iowa | 2.3 |
| Kansas | 8.3 |
| Kentucky | 8.9 |
| Louisiana | 37.5 |
| Maine | 0.6 |
| Maryland | 30.2 |
| Massachusetts | 7.1 |
| Michigan | 16.5 |
| Minnesota | 2.5 |
| Mississippi | 47.5 |
| Missouri | 15.4 |
| Montana | 0.5 |
| Nebraska | 5.1 |
| Nevada | 10.2 |
| New Hampshire | 0.7 |
| New Jersey | 20.0 |
| New Mexico | 2.6 |
| New York | 21.5 |
| North Carolina | 28.7 |
| North Dakota | 1.1 |
| Ohio | 14.1 |
| Oklahoma | 9.5 |
| Oregon | 2.5 |
| Pennsylvania | 13.0 |
| Rhode Island | 6.8 |
| South Carolina | 39.1 |
| South Dakota | 0.8 |
| Tennessee | 22.1 |
| Texas | 13.6 |
| Utah | 0.8 |
| Vermont | 0.3 |
| Virginia | 23.9 |
| Washington | 4.4 |
| West Virginia | 3.9 |
| Wisconsin | 6.9 |
| Wyoming | 1.1 |

Table 3 — Black IMRs With and Without <500 Gram Births, 1983 U.S. Data

| State | IMR | IMR Minus <500 gm | % IMR Decline |
|---|---|---|---|
| U.S. | 19.2 | 16.3 | 15.1 |
| Alabama | 18.5 | 17.2 | 7.0 |
| Alaska* | 21.0 | 17.2 | 18.1 |
| Arizona* | 20.7 | 17.3 | 16.4 |
| Arkansas* | 15.6 | 14.6 | 6.4 |
| California | 16.7 | 13.2 | 21.0 |
| Colorado* | 15.5 | 12.3 | 20.6 |
| Connecticut | 19.6 | 14.2 | 27.6 |
| Delaware | 17.3 | 11.3 | 34.7 |
| Dist. Columbia | 21.3 | 17.7 | 16.9 |
| Florida | 19.3 | 16.9 | 12.4 |
| Georgia | 19.8 | 16.7 | 15.7 |
| Hawaii* | 11.3 | 8.8 | 22.1 |
| Idaho* | 43.0 | 43.0 | 0.0 |
| Illinois | 23.1 | 19.6 | 15.2 |
| Indiana | 18.1 | 15.2 | 16.0 |
| Iowa* | 21.8 | 18.8 | 13.8 |
| Kansas | 15.3 | 12.0 | 21.6 |
| Kentucky | 18.1 | 16.0 | 11.6 |
| Lousiana | 19.9 | 16.9 | 15.1 |
| Maine* | 20.6 | 10.4 | 49.5 |
| Maryland | 18.6 | 14.7 | 21.0 |
| Massachusetts | 16.8 | 14.6 | 13.1 |
| Michigan | 23.1 | 18.8 | 18.6 |
| Minnesota* | 22.5 | 18.9 | 16.0 |
| Mississippi | 20.0 | 17.0 | 10.5 |
| Missouri | 19.1 | 16.1 | 15.7 |
| Montana* | 28.2 | 28.2 | 0.0 |
| Nebraska* | 16.6 | 15.1 | 9.0 |
| Nevada* | 17.9 | 15.2 | 15.1 |
| New Hampshire* | 21.1 | 21.1 | 0.0 |
| New Jersey | 19.4 | 16.5 | 14.9 |
| New Mexico* | 12.6 | 7.0 | 44.4 |
| New York | 18.1 | 16.5 | 8.8 |
| North Carolina | 19.6 | 16.2 | 17.3 |
| North Dakota* | 7.4 | 7.4 | 0.0 |
| Ohio | 19.5 | 16.6 | 14.9 |
| Oklahoma | 14.9 | 12.9 | 13.4 |
| Oregon* | 16.3 | 11.3 | 30.7 |
| Pennsylvania | 21.1 | 17.2 | 18.5 |
| Rhode Island* | 22.2 | 21.1 | 5.0 |
| South Carolina | 20.9 | 18.1 | 13.4 |
| South Dakota* | 10.0 | 0.0 | 100.0 |
| Tennessee | 20.3 | 17.3 | 14.8 |
| Texas | 16.3 | 13.9 | 14.7 |
| Utah* | 6.6 | 3.3 | 50.0 |
| Vermont* | 87.0 | 87.0 | 0.0 |
| Virginia | 20.0 | 16.4 | 18.0 |
| Washington* | 18.5 | 16.5 | 10.8 |
| West Virginia* | 17.7 | 12.9 | 27.1 |
| Wisconsin | 16.4 | 12.9 | 21.3 |
| Wyoming* | 9.2 | 9.2 | 0.0 |

* <10 black births under 500 grams

**Table 4 — White IMR With and Without <500 Gram Births, 1983 U.S. Data**

| *State* | *IMR* | *IMR Minus <500 gm* | *% IMR Decline* |
|---|---|---|---|
| U.S. | 9.7 | 8.9 | 8.2 |
| Alabama | 10.3 | 9.7 | 5.8 |
| Alaska* | 10.7 | 10.0 | 6.5 |
| Arizona | 8.9 | 8.5 | 4.5 |
| Arkansas | 9.1 | 8.6 | 5.5 |
| California | 9.4 | 8.5 | 9.6 |
| Colorado | 10.0 | 9.2 | 8.0 |
| Connecticut | 8.9 | 7.6 | 14.6 |
| Delaware* | 7.3 | 6.4 | 12.3 |
| Dist. Columbia* | 11.6 | 9.3 | 19.8 |
| Florida | 9.9 | 9.0 | 9.1 |
| Georgia | 9.9 | 8.8 | 11.1 |
| Hawaii* | 10.3 | 9.7 | 5.8 |
| Idaho | 10.7 | 10.0 | 6.5 |
| Illinois | 9.7 | 8.5 | 12.4 |
| Indiana | 10.7 | 9.7 | 9.3 |
| Iowa | 8.6 | 7.9 | 8.1 |
| Kansas | 10.0 | 8.9 | 11.0 |
| Kentucky | 11.0 | 10.0 | 9.1 |
| Lousiana | 9.8 | 9.0 | 8.2 |
| Maine | 8.7 | 8.0 | 8.0 |
| Maryland | 8.9 | 8.1 | 9.0 |
| Massachusetts | 8.5 | 7.6 | 10.6 |
| Michigan | 9.6 | 8.4 | 12.5 |
| Minnesota | 9.6 | 8.7 | 9.4 |
| Mississippi* | 10.7 | 10.3 | 3.7 |
| Missouri | 9.2 | 8.4 | 8.7 |
| Montana* | 8.6 | 8.4 | 2.3 |
| Nebraska | 9.5 | 9.0 | 5.3 |
| Nevada* | 10.4 | 10.0 | 3.8 |
| New Hampshire | 8.6 | 7.8 | 9.3 |
| New Jersey | 9.5 | 8.6 | 9.5 |
| New Mexico | 9.8 | 9.1 | 7.1 |
| New York | 9.9 | 9.1 | 8.1 |
| North Carolina | 10.5 | 9.5 | 9.5 |
| North Dakota* | 8.5 | 8.0 | 5.9 |
| Ohio | 9.8 | 8.9 | 9.2 |
| Oklahoma | 10.7 | 10.0 | 6.5 |
| Oregon | 9.6 | 9.0 | 6.3 |
| Pennsylvania | 9.8 | 9.0 | 8.2 |
| Rhode Island | 11.0 | 9.5 | 13.6 |
| South Carolina | 11.3 | 10.5 | 7.1 |
| South Dakota* | 8.3 | 8.0 | 3.6 |
| Tennessee | 10.7 | 9.8 | 8.4 |
| Texas | 10.4 | 9.7 | 6.7 |
| Utah | 8.9 | 8.3 | 6.7 |
| Vermont | 8.5 | 6.9 | 18.8 |
| Virginia | 9.6 | 8.6 | 10.4 |
| Washington | 9.2 | 8.4 | 8.7 |
| West Virginia | 10.7 | 10.2 | 4.7 |
| Wisconsin | 9.0 | 8.0 | 11.1 |
| Wyoming* | 9.9 | 9.4 | 5.1 |

* <10 white births under 500 grams

Waycross) of the six districts with the smallest decreases after recalculation.

The same calculations were performed for black (Table 7) and white (Table 8) IMRs. The recalculated black IMRs for six districts (Cobb-Douglas, Fulton, Macon, Albany, Savannah, Brunswick) declined at least 13% when deaths to black infants with birthweights <500 grams were excluded from the calculations (Table 7). Dalton's relatively large change in IMR after eliminating the <500 gram category is the result of a large change in the white IMR (Table 8). Districts where both black and white recalculated IMRs decreased by more than 10% include Cobb-Douglas, Fulton, Macon, and Brunswick — four of the seven districts with the largest IMR changes.

***"The problem of preterm labor and its multiple socioeconomic, medical, and community determinants will not disappear if Georgia changes its live birth definition."***

### Discussion

Georgia's live birth definition conforms to most state, national, and international definitions. No state officially uses a 500 gram lower limit in its live birth definition.

Excluding births <500 grams from state IMR calculations results in a 14% decrease in Georgia's IMR. However, one-fifth of all states show similar or greater reductions. The recalculation improves Georgia's national IMR ranking only two positions, from 47th to 45th. While the percentage of black births appears to play a role in the effect on individual state IMRs, states most affected by the recalculation have large reductions for both black and white IMRs.

Table 5 — District IMRs and Rankings With and Without <500 Gram Birthweight Infants, 1980-1983 IDFF (Births 1980-1982)

| District | District Name | IMR | RANK | IMR Minus <500 gm | Rank Minus <500 gm | % IMR Decrease |
|---|---|---|---|---|---|---|
| 1-1 | Rome | 10.2 | 2 | 9.5 | 2 | 6.9 |
| 1-2 | Dalton | 11.2 | 4 | 9.8 | 3 | 12.5 |
| 2-0 | Gainesville | 11.5 | 6 | 11.0 | 7 | 4.3 |
| 3-1 | Cobb-Douglas | 11.4 | 5 | 10.1 | 4 | 11.4 |
| 3-2 | Fulton | 16.9 | 17 | 14.8 | 17 | 12.4 |
| 3-3 | Clayton | 11.1 | 3 | 10.2 | 5 | 8.1 |
| 3-4 | Gwinnett | 10.0 | 1 | 9.4 | 1 | 6.0 |
| 3-5 | DeKalb | 13.9 | 10 | 12.6 | 11 | 9.4 |
| 4-0 | LaGrange | 14.9 | 14 | 13.7 | 15 | 8.1 |
| 5-1 | Dublin | 15.2 | 16 | 13.9 | 16 | 8.6 |
| 5-2 | Macon | 14.5 | 12 | 12.3 | 10 | 15.2 |
| 6-0 | Augusta | 11.7 | 7 | 11.1 | 8 | 5.1 |
| 7-0 | Columbus | 16.9 | 17 | 15.4 | 18 | 8.9 |
| 8-1 | Valdosta | 13.9 | 10 | 13.2 | 13 | 5.0 |
| 8-2 | Albany | 18.0 | 19 | 15.6 | 19 | 13.3 |
| 9-1 | Savannah | 15.1 | 15 | 12.7 | 12 | 15.9 |
| 9-2 | Waycross | 12.4 | 9 | 11.5 | 9 | 7.3 |
| 9-3 | Brunswick | 12.1 | 8 | 10.5 | 6 | 13.2 |
| 10.0 | Athens | 14.7 | 13 | 13.5 | 14 | 8.8 |

Table 6 — Percentage of Black Births, By Districts, 1980-1982 Georgia IDFF

| District | District Name | Percentage of Black Births |
|---|---|---|
| 1-1 | Rome | 11.1 |
| 1-2 | Dalton | 2.4 |
| 2-0 | Gainesville | 10.1 |
| 3-1 | Cobb-Douglas | 7.7 |
| 3-2 | Fulton | 67.5 |
| 3-3 | Clayton | 12.8 |
| 3-4 | Gwinnett | 8.9 |
| 3-5 | DeKalb | 44.7 |
| 4-0 | LaGrange | 33.4 |
| 5-1 | Dublin | 41.1 |
| 5-2 | Macon | 47.6 |
| 6-0 | Augusta | 47.8 |
| 7-0 | Columbus | 50.0 |
| 8-1 | Valdosta | 40.6 |
| 8-2 | Albany | 50.3 |
| 9-1 | Savannah | 46.2 |
| 9-2 | Waycross | 33.1 |
| 9-3 | Brunswick | 38.4 |
| 10-0 | Athens | 32.9 |

When deaths to infants with birthweights <500 grams are excluded from IMR calculations for Georgia health districts, the greatest improvements are in districts with urban centers and a large percentage of black live births. Some of these urban areas also have tertiary neonatal centers. However, there are notable exceptions which limit the interpretation of these observations.

Including live births with birthweights <500 grams in Georgia live birth and infant mortality data increases state and district IMRs but has little impact on the relative position of the state IMR vis-à-vis other states or the state health districts compared with each other. Moreover, the issue is not what to label these births and deaths (fetal versus neonatal), but rather why are they born so small and so prematurely. The problem of preterm labor and its multiple socioeconomic, medical, and community determinants will not disappear if Georgia changes its live birth definition. Georgia's goal of nine infant deaths per 1000 live births by 1990 involves more than just statistical manipulation of existing data. The fact remains that these babies were not carried to term. The reasons need to be discovered and corrected.


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**Table 7 — Black IMRs With and Without <500 Gram Infant Deaths, 1980-1982 Georgia IDFF**

| *District* | *District Name* | *IMR* | *IMR Minus <500 gm* | *% IMR Decrease* |
|---|---|---|---|---|
| 1-1 | Rome | 18.2 | 16.0 | 12.1 |
| 1-2 | Dalton | 24.8 | 24.8 | 0.0 |
| 2-0 | Gainesville | 23.0 | 20.2 | 12.2 |
| 3-1 | Cobb-Douglas | 23.5 | 20.5 | 12.8 |
| 3-2 | Fulton | 20.0 | 17.3 | 13.5 |
| 3-3 | Clayton | 27.8 | 24.9 | 10.4 |
| 3-4 | Gwinnett | 14.9 | 14.9 | 0.0 |
| 3-5 | DeKalb | 19.3 | 17.0 | 11.9 |
| 4-0 | LaGrange | 21.6 | 18.9 | 12.5 |
| 5-1 | Dublin | 24.0 | 21.5 | 10.4 |
| 5-2 | Macon | 17.8 | 14.8 | 16.9 |
| 6-0 | Augusta | 15.5 | 14.4 | 7.1 |
| 7-0 | Columbus | 21.8 | 19.9 | 8.7 |
| 8-1 | Valdosta | 23.2 | 21.5 | 7.3 |
| 8-2 | Albany | 25.7 | 21.9 | 14.8 |
| 9-1 | Savannah | 21.6 | 17.6 | 18.5 |
| 9-2 | Waycross | 21.6 | 20.4 | 5.6 |
| 9-3 | Brunswick | 16.8 | 14.6 | 13.1 |
| 10-0 | Athens | 26.7 | 24.3 | 9.0 |

**Table 8 — White IMRs With and Without <500 Gram Infant Deaths, 1980-1982 Georgia IDFF**

| *District* | *District Name* | *IMR* | *IMR Minus <500 gm* | *% IMR Decline* |
|---|---|---|---|---|
| 1-1 | Rome | 9.2 | 8.7 | 5.4 |
| 1-2 | Dalton | 10.8 | 9.4 | 13.0 |
| 2-0 | Gainesville | 10.2 | 10.0 | 2.0 |
| 3-1 | Cobb-Douglas | 10.4 | 9.2 | 11.5 |
| 3-2 | Fulton | 10.5 | 9.4 | 10.5 |
| 3-3 | Clayton | 8.6 | 8.0 | 7.0 |
| 3-4 | Gwinnett | 9.5 | 8.8 | 7.4 |
| 3-5 | DeKalb | 9.6 | 9.0 | 6.3 |
| 4-0 | LaGrange | 11.6 | 11.1 | 4.3 |
| 5-1 | Dublin | 9.0 | 8.7 | 3.3 |
| 5-2 | Macon | 11.4 | 10.0 | 12.3 |
| 6-0 | Augusta | 8.3 | 8.1 | 2.4 |
| 7-0 | Columbus | 12.0 | 10.9 | 9.2 |
| 8-1 | Valdosta | 7.5 | 7.5 | 0.0 |
| 8-2 | Albany | 10.2 | 9.3 | 8.8 |
| 9-1 | Savannah | 9.4 | 8.5 | 9.6 |
| 9-2 | Waycross | 7.8 | 7.1 | 9.0 |
| 9-3 | Brunswick | 9.1 | 7.9 | 13.2 |
| 10-0 | Athens | 8.7 | 8.2 | 5.7 |

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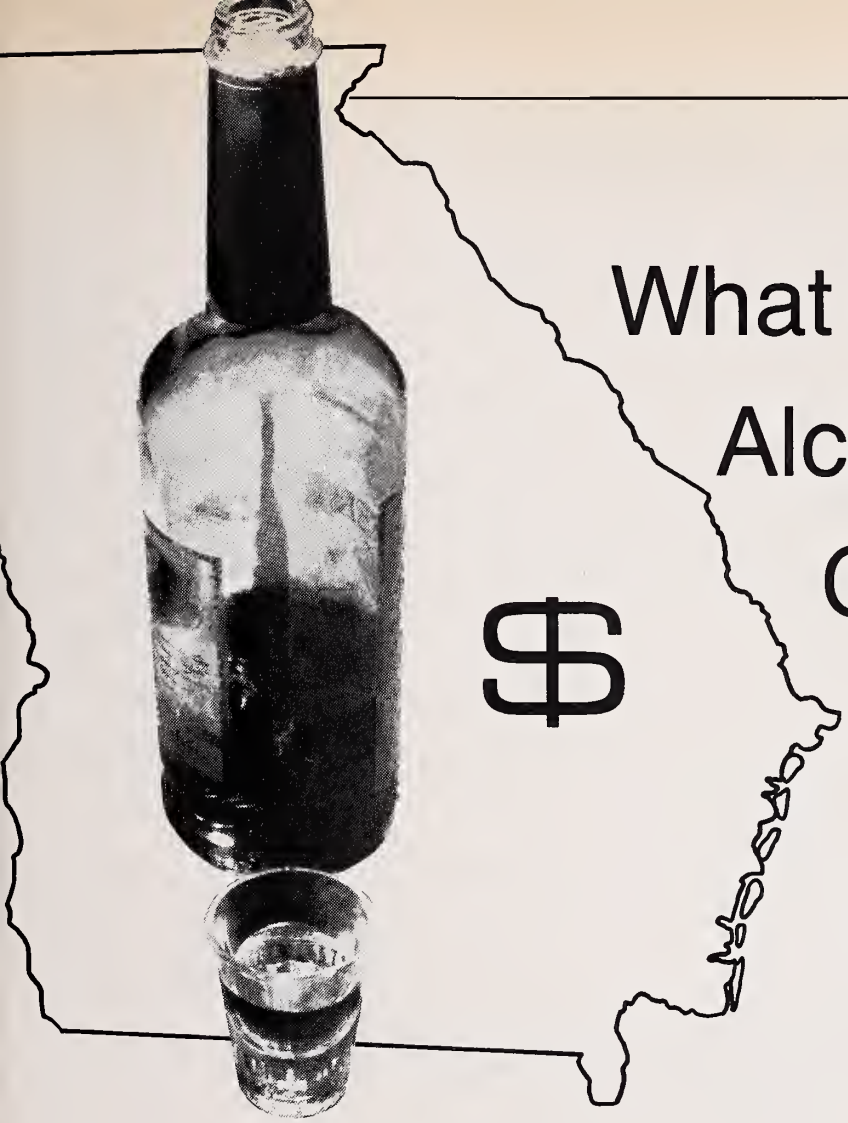

# What Does Alcohol Consumption Cost Georgia?

Jeffrey J. Sacks, M.D., M.P.H.
R. Keith Sikes, D.V.M., M.P.H.

THE RECENT ATTENTION given to drinking and driving has done much to focus public attention on the fact that alcohol can kill. However, the average citizen may be unaware of the contribution of alcohol to other deaths from injuries, cancer, gastrointestinal diseases, mental illness, and other disorders. In view of the ever increasing consumption of alcohol in Georgia (Figure 1), we offer the following analysis of some of the health-related costs of alcohol.

The Minnesota Department of Health has recently derived some estimates of the total mortality associated with the use of alcohol.[1, 2] Their methods have been applied to Georgia mortality in a manner similar to the approach used to calculate the mortality associated with cigarette smoking in Georgia (see Georgia Epidemiology Report, August 1985). Using estimates obtained from a variety of studies cited in the Minnesota report, we calculated the proportion of deaths associated with alcohol for Georgia residents in 1984. Some causes of death, such as alcoholic cirrhosis, were alcohol-associated by definition. Others, such as esophageal cancer, were considered alcohol-associated because they occur more frequently among drinkers than non-drinkers. Still others, such as deaths from boating fatalities, were deemed alcohol-associated because the decedants had elevated blood alcohol concentrations at death. As seen in Table 1, *5.4% of all deaths and 13.4% of all the years of potential life lost in Georgia in 1984 were associated with alcohol.* Deaths from injuries contributed the greatest amount to the alcohol-associated mortality. Interestingly, the burden of alcohol-associated deaths was not shared equally between the sexes (Table 2). For every category of cause of death, Georgia males exceeded females.

Dr. Sacks is Assistant State Epidemiologist, and Dr. Sikes is State Epidemiologist, Office of Epidemiology, Georgia Department of Human Resources.

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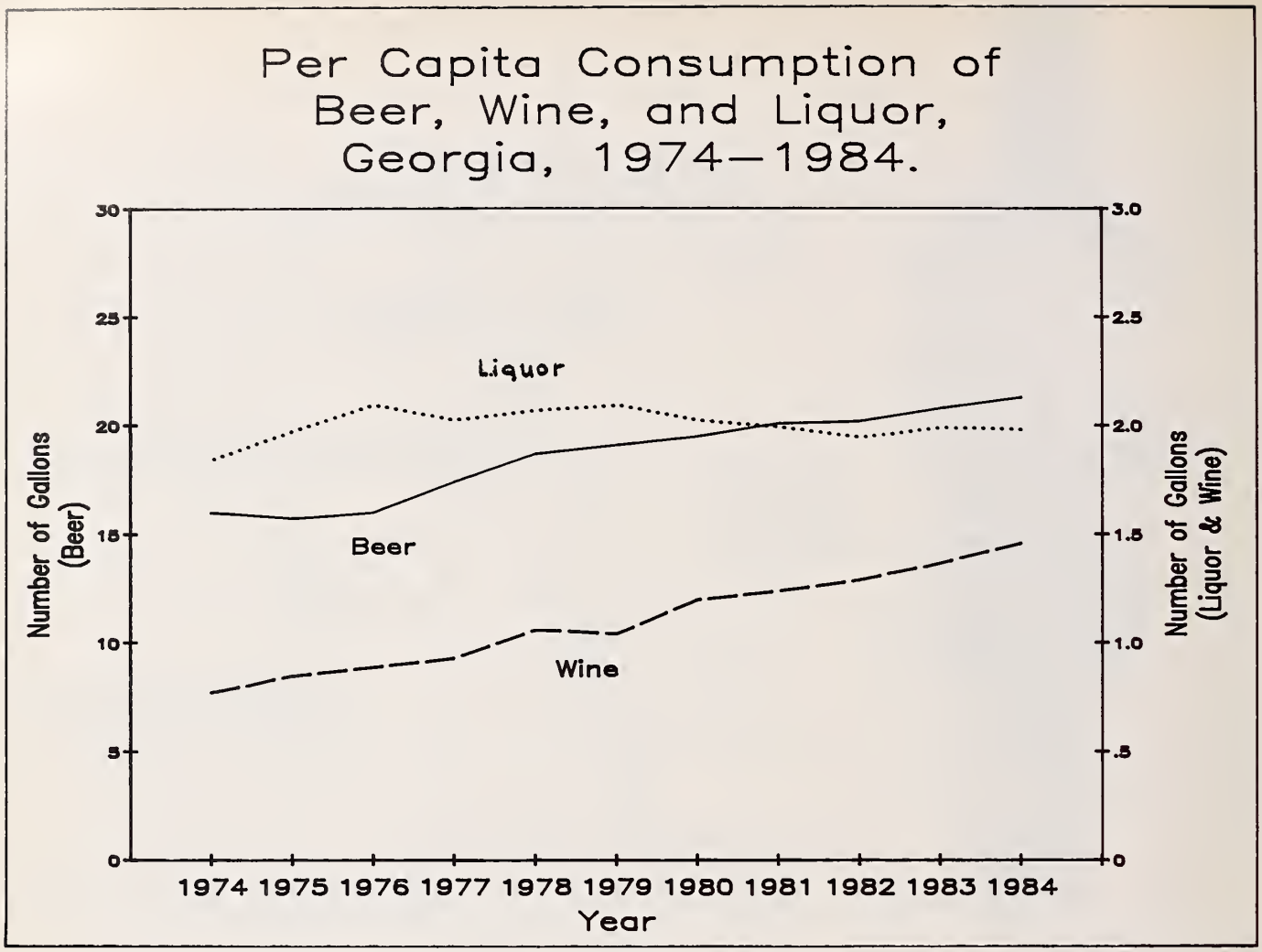


The direct medical costs from alcohol-associated diseases are staggering (Table 3). *Almost 8% of all direct care costs are associated with alcohol.* These estimates do not include indirect costs, such as lost income, disability, and decreased productivity.

***"Almost 8% of all direct medical care costs in 1984 were associated with alcohol. These estimates do not include indirect costs, such as lost income, disability, and decreased productivity."***

In order to compare costs and benefits, data on funds generated by alcoholic beverages were obtained from the Georgia Department of Revenue (Table 4). Comparison of Tables 3 and 4 indicate that for *every $1.00 in income, $5.72 was spent for direct health care costs for alcohol-associated diseases.*

*EDITORIAL NOTE: It should be appreciated that the estimates of the proportion of deaths used in each disease category in this study were at the lower or middle end of the spectrum, i.e., they were conservative. Moreover, a number of conditions related to alcohol were not included (e.g., fetal alcohol syndrome) and other diseases where the relationship to alcohol has not been clearly elucidated. A number of social costs were also not considered, such as motor-vehicular and fire-related property damage, costs of incarceration, absenteeism and injuries at work, decreased productivity, and child abuse and neglect.*

*On-going behavioral risk factor surveys among Georgia adults have found that in 1984, 59.2% of males and 36.8% of females had consumed alcohol during the past month. Of the consumers, 46.2% of males and 22.7% of females stated that they had consumed more than 5 drinks on one occasion during that month. Finally,* 5% of adults (8.5% of males, 3.1% of females) stated that they had driven one or more times during the last month after having had too much to drink. *This*

**TABLE 1 — Deaths and Years of Potential Life Lost (YPLL)* Associated With Alcohol, Georgia Residents, 1984**

| *Cause of Death* | *No. of deaths* | *Alcohol-associated* | |
|---|---|---|---|
| | | *No. of deaths* | *YPLL* |
| Injuries: | 4,193 | 1,489 | 46,616 |
| Motor vehicle related | 1,425 | 713 | 25,700 |
| Suicides | 728 | 189 | 4,859 |
| Homicides | 676 | 284 | 9,811 |
| Falls | 338 | 139 | 1,244 |
| Fires | 204 | 86 | 2,412 |
| Drownings | 138 | 41 | 1,787 |
| Asphyxiation | 93 | 4 | 63 |
| Alcohol poisoning | 24 | 24 | 591 |
| Hypothermia | 19 | 9 | 149 |
| Gastrointestinal diseases: | 1,751 | 425 | 6,340 |
| Cirrhosis | 364 | 182 | 2,315 |
| Alcoholic cirrhosis | 209 | 209 | 3,607 |
| Acute pancreatitis | 71 | 30 | 370 |
| Chronic pancreatitis | 7 | 4 | 48 |
| Nutritional disorders: | 1,154 | 246 | 4,302 |
| Alcoholism | 210 | 210 | 3,592 |
| Alcohol abuse | 36 | 36 | 710 |
| Cancers: | 9,745 | 328 | 2,483 |
| Oral cavity | 230 | 108 | 857 |
| Esophagus | 200 | 150 | 1,123 |
| Liver | 135 | 20 | 139 |
| Larynx | 104 | 50 | 364 |
| Circulatory diseases: | 21,647 | 20 | 395 |
| Alcoholic cardiomyopathy | 20 | 20 | 395 |
| Mental disorders: | 516 | 17 | 230 |
| Alcoholic psychosis | 17 | 17 | 230 |
| Infectious diseases: | 690 | 5 | 39 |
| Tuberculosis | 54 | 5 | 39 |
| Total alcohol-associated | | 2,530 | 60,405 |
| Total all other causes | 40,793 | 0 | 376,327 |
| Grand total | 46,631 | 2,530 | 436,732 |

*YPLL calculated on the basis of a 70-year life expectancy.

**TABLE 2 — Alcohol-Associated YPLL, by Cause and Sex, Georgia, 1984**

| *Cause* | *YPLL* | | |
|---|---|---|---|
| | *Females* | *Males* | *Total* |
| Injuries | 12,320 | 34,296 | 46,616 |
| Gastrointestinal diseases | 2,314 | 4,026 | 6,340 |
| Nutritional disorders | 1,357 | 2,945 | 4,302 |
| Cancer | 564 | 1,919 | 2,483 |
| Circulatory diseases | 93 | 302 | 395 |
| Mental disorders | 88 | 142 | 230 |
| Infectious diseases | 13 | 26 | 39 |
| Total | 16,749 | 43,656 | 60,405 |

*translates into at least 133,120 drivers impaired by alcohol on the road in Georgia during any given month in 1984.*

*Of the 2,530 deaths associated with alcohol, 516 (20%) were truly attributable to alcohol (i.e., deaths due to alcoholic cardiomyopathy and cirrhosis, alcohol abuse and poisoning, and alcoholism). That is, if alcohol did not exist, these deaths would not have occurred. The remainder of the deaths, especially those from injuries, were probably caused only in part by alcohol, since some of them might have occurred anyway. Although a precise tally of the number of deaths truly caused by alcohol is impossible to*

TABLE 3 — Alcohol-Associated Direct Health Care Costs, by Disease Category, Georgia, 1984

| *Disease category* | *Total Costs* | *Proportion Alcohol-Related* | *Total Alcohol-Related Costs* |
|---|---|---|---|
| Infectious diseases | $ 159,578,558 | .00725 | $ 1,156,945 |
| Cancer | 483,406,266 | .03366 | 16,271,455 |
| Circulatory | 1,177,300,543 | .00092 | 1,083,117 |
| Gastrointestinal | 1,126,391,091 | .24272 | 273,397,646 |
| Injuries | 682,918,386 | .35512 | 242,517,978 |
| Mental | 720,283,121 | .03295 | 23,733,329 |
| Nutritional | 271,672,765 | .21317 | 57,912,484 |
| All causes | $7,784,319,908 | | $616,072,954 |

TABLE 4 — Tax Revenues From Alcoholic Beverages, Georgia, FY 1984

| | *Type of Revenue* | | |
|---|---|---|---|
| *Type of Beverage* | *Sales Tax* | *Permits* | *Total* |
| Liquor | $ 38,361,446 | $ 436,350 | $ 38,797,796 |
| Beer | 55,100,650 | 749,975 | 55,850,625 |
| Wine | 12,492,723 | 534,725 | 13,027,448 |
| Total | $105,954,819 | $1,721,050 | $107,675,869 |

*obtain, the number reported here is probably a reasonable, if somewhat conservative, estimate. Just as with cigarette smoking, an important part of the debate concerning risks and benefits involves a delineation of the facts. It is our hope that this analysis will help clarify some of the costs attendant to the consumption of alcohol in Georgia.*


## Acknowledgment

Special thanks to Don Gambrell and Mike LaVoie of the Georgia Dept. of Human Resources, Center for Health Statistics.


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# FIFTEEN-YEAR REVIEW OF EXTRACRANIAL CAROTID ARTERY INJURY

BILL H. MOSES, JR., M.D., MARY ANN TOLSON, R.N.,
CARL R. BOYD, M.D.

## Introduction

SINCE THE FIRST reported ligation of a lacerated common carotid artery in 1803, the surgical management of this entity has been a subject of controversy in the forum of trauma care. Due to the relatively infrequent occurrence of this injury, experience in any single institution is somewhat limited, and the literature is often anecdotal. Issues addressed in this paper include restoration of flow in the face of neurologic deficit and guidelines for preoperative evaluation of the injury.

## Methods

We reviewed 15 years of experience in extracranial carotid artery injury at Memorial Medical Center between the years 1970 and 1985. Patients with injuries to the external carotid artery were eliminated unless there was concomitant injury to the internal or common carotid artery. A total of 13 patients with injury to the internal or common carotid artery were reviewed. The charts were reviewed for mechanism of injury, evaluation of injury, criteria for operative intervention, and operative management.

Patients with neck injuries may have a life-threatening injury with a deceptively benign presentation requiring a high index of suspicion in the initial evaluation. Arterial bruits, expanding hematomas, and brisk external bleeding are some of the more obvious signs of vascular injury. Neurologic impairment associated with injury to the carotid artery may range from minimal deficit to deep coma.

In patients who present with penetrating neck injury, it is our policy to describe the injury location by anatomical zone (Figure 1). Zone I extends from the clavicle to the cricoid cartilage. Zone II is from the cricoid to the angle of the mandible, and Zone III is cephalad from this point. Stable patients with injuries in Zones I and III are taken for arteriography. Wounds in Zone II mandate neck exploration if the platysma muscle has been violated. Local wound exploration in the Emergency Department is not done.

## Results

In 70% of the 13 patients, the injury was secondary to gunshot wound or stabbing. The remainder were a result of blunt injury, including hyperextension and rotational changes in neck position, crush injury, and fracture of the mandible, all associated with motor vehicle accidents. The fourth blunt injury was secondary to high speed impact with a steel cable.

Four of the 13 patients were hypotensive on admission to the Emergency Department (BP less than 90). The mortality of this group was 50%, compared to an 11% mortality among the nine patients who were normotensive. This was the only significant difference in the two groups.

All patients without neurologic deficit and five of the six patients with neurologic deficit short of coma underwent revascularization. Two patients who presented with coma (unresponsive to verbal stimuli) were seen. One patient underwent carotid artery ligation, and one patient was treated non-operatively.

The operative management and outcome for patients without neurologic deficit (Figure 2) and for those with neurologic deficit (Figure 3) are depicted. Both patients who presented with coma expired. One patient struck by a steel cable suffered left hemiparesis from a right hemispheric infarction resulting from total occlusion of the right internal carotid artery. The patient was managed expectantly, and with an intensive re-

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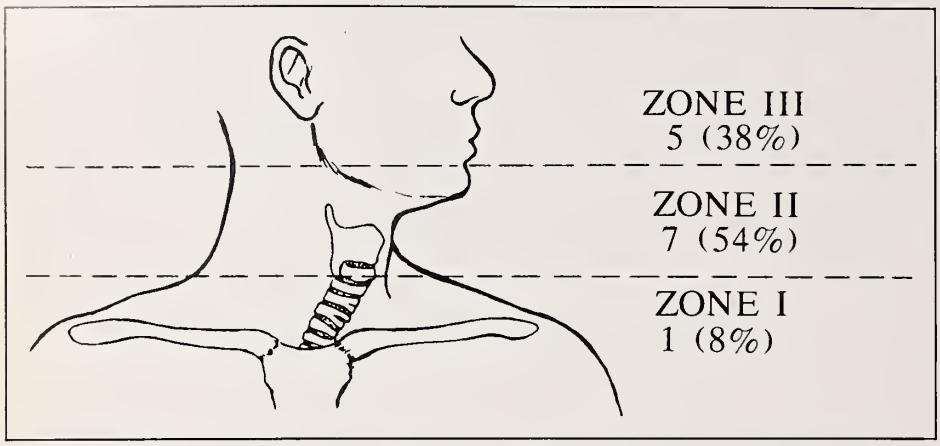


*Figure 1 — Distribution of penetrating neck injury by anatomical zone.*

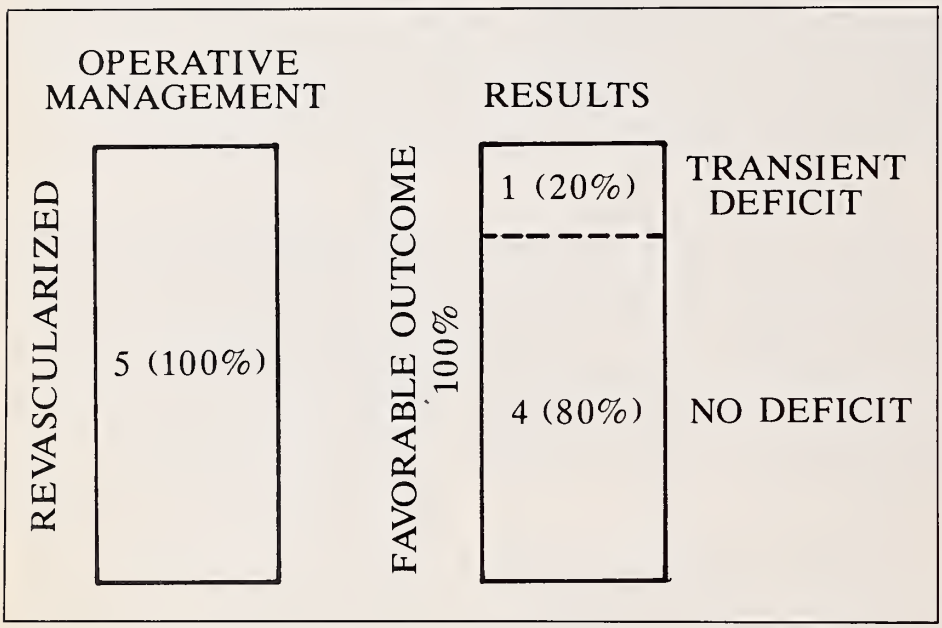


*Figure 2 — Operative management and outcome in patients without pre-operative neurologic deficit.*

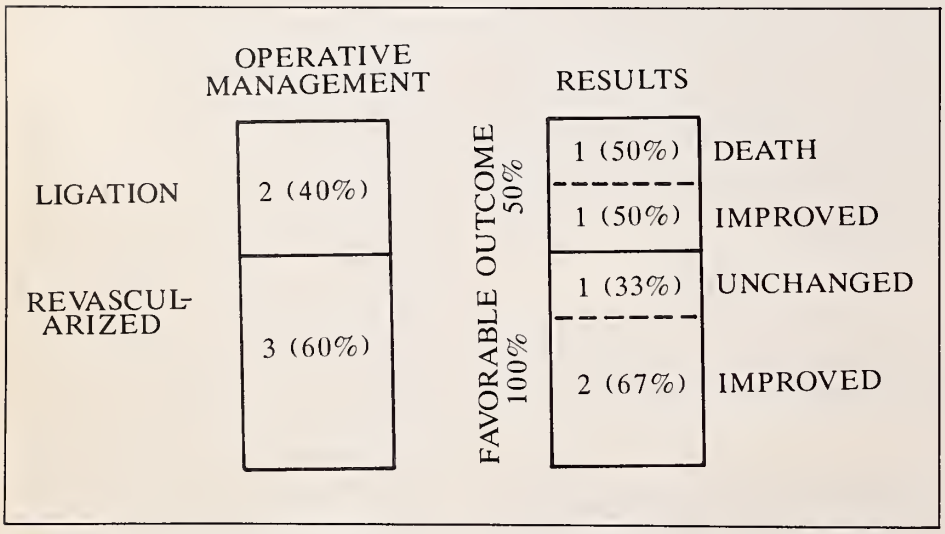


*Figure 3 — Operative management and outcome in patients with pre-operative neurologic deficit up to coma.*

habilitative effort recovered independence in activities of daily living by time of discharge.

## Discussion

Carotid vessels comprise 90% of cerebral vascular supply, while the vertebral system contributes 10%. Interruption of flow in either of these systems results in an increased flow of alternate blood supply to the Circle of Willis. This classic anatomy, however, is present in only 20% of the population. An older school of thought proposed liberal ligation of the injured carotid artery in the presence of neurologic deficit. Liberal ligation was proposed because of the poor experience with revascularization in the acute stroke patient. However, there are significant differences in the patient with acute interrupution of flow from a stroke. In trauma, the patients are usually young, and the injury is to an isolated vessel. The stroke patient is almost always in his 60s or 70s, and the disease is diffuse. It is theorized that areas of cerebral infarction resulting from carotid injury are surrounded by a larger concentric zone of relative ischemia which may benefit from restoration of flow.

The results in this series and a review of the available literature on this uncommon injury lead us to offer the following recommendations for management of the patient with injury to the extracranial carotid artery:

1) Stable patients with wounds in Zones I and III should undergo arteriography.
2) Patients with wounds in Zone II which violate the platysma should be explored.
3) Restoration of vascular continuity should be accomplished in all patients with neurologic deficit, patients with neurologic deficit exclusive of coma, and comatose patients with prograde flow.
4) Ligation of the carotid artery for injury is indicated only when repair is technically impossible or in the comatose patient with no prograde flow.

Although this review includes no comatose patient undergoing revas-

| Pt | Mechanism | Zone & Vessel(s) Involved | Neurologic Deficit Pre-Op | Neurologic Deficit Post-Op | Repair | Associated Injuries | Comments |
|---|---|---|---|---|---|---|---|
| 1 | GSW | I, CC | none | neuropraxia L arm | end-to-end anastomosis L com car — ligation LIJ & L vertebral art | LIJ, L vertebral art — Fx transverse cervical vertebra | Hypotensive |
| 2 | Stab | II, IC | none | none | 1°, drain | none | |
| 3 | Stab | II, CC | none | none | 1°, drain — ligation LIJ | LIJ | Arteriogram done pre-op |
| 4 | GSW | II, CC | none | none | 1°, drain | none | |
| 5 | GSW | II, CC | not moving L arm | Brown-Sequard — hemiparesis L arm, L foot, R hand (2° to cord lesion) | end-to-end anastomosis L com car — lig LIJ — drain | LIJ C5 fracture | Bullet in cord at C5-6 — decompression laminectomy done without improvement of neuro status — hypotensive in field |
| 6 | Struck by shotgun barrel | II, CC, IC | Hemiplegia L arm — L Babinski | Hemiplegia cleared by discharge | Thrombectomy with 1° repair RIC — ligation RIJ at base of skull | RIJ | Neck laceration sewn by LMD prior to transfer — external carotid sheared off — internal carotid clotted off |
| 7 | Assault | II, IC | None on adm — day 2 lethargic, R hemiplegia, aphasia, R Babinski | Comatose | Ligation LIC — packed distally | Fractured mandible — Pneumothorax on L — Fx C5 spinous process | Died — multiple stab wounds — arteriogram done day 2 — postop cerebral edema, respiratory distress, L pupil blown — trached — arrested × 2 — hypotensive in field |
| 8 | Stab | III, IC, EC | none | none | 1° repair 4 days post injury | R facial nerve transected | Repair of facial laceration in ED, then dc'd home — returned to hospital 2 days later — arteriogram showed pseudoaneurysm RIC, occluded REC |
| 9 | GSW | III, EC, IC | Mild R sided weakness | R sided weakness cleared by POD #2 | Ligation | Contused liver — L superficial temporal artery — grazed R arm | Arteriogram showed pseudoaneurysm LIC 2 cm from base of skull |
| 10 | GSW | III, CC | RUE hemiplegia | Weakness R hand only (continued deficit on followup) | Ligation LEC — saphenous bypass | Fractured mandible | Trached preop because of difficult intubation 2° to injury |
| 11 | Struck by steel cable | III, IC | None on adm — L hemiparesis 2 days post injury | — | none | Subdural hematoma — Extensive open, depressed facial Fxs | Traumatic dissection of RIC with R hemispheric infarction day 2 — independent in ADLs by discharge |
| 12 | GSW | Diffuse area of injury 2° to shotgun blast | — Comatose | — | ligation L com car, L int/ext car, LIJ, com facial artery | Massive soft tissue and head injury | Died — pupils fixed & dilated on arrival to ED — hypotensive in field |
| 13 | AA | Diffuse, IC | — Comatose | — | none | Multiple facial and skull fractures | Died — Orbital bruits heard day #2 prompting arteriogram |

cularization, the above recommendations for the management of the comatose patient are supported by the reported cumulative experience on the subject.

### Summary

Fifteen years of experience in the management of extracranial carotid artery injury, representing 13 patients with injury to the internal or common carotid artery were reviewed. The mode of injury was penetrating in 70% of the cases, while 30% were the result of blunt injury. Penetrating injuries with wounds in Zones I and III in the stable patient demand early arteriography. Wounds in Zone II mandate neck exploration if the platysma has been violated. Local wound exploration in the Emergency Department is condemned. Hypotension on admission portends a poor prognosis. Revascularization in patients without neurologic deficit or deficit short of coma results in a 100% favorable outcome. Although the management of carotid artery injury in the comatose patient remains controversial, the young age group and localized process would seem to favor a management different from that of the stroke patient.

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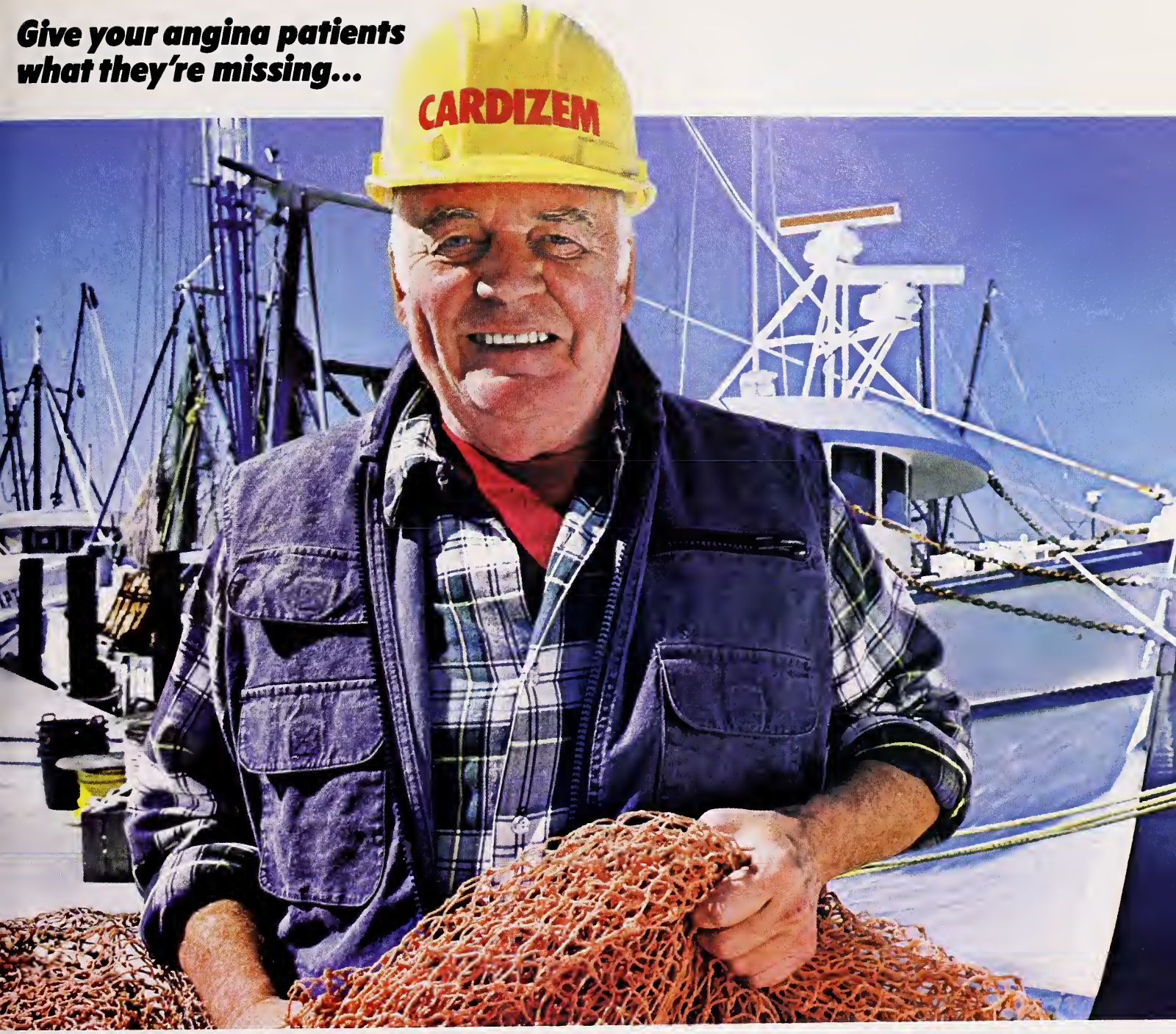


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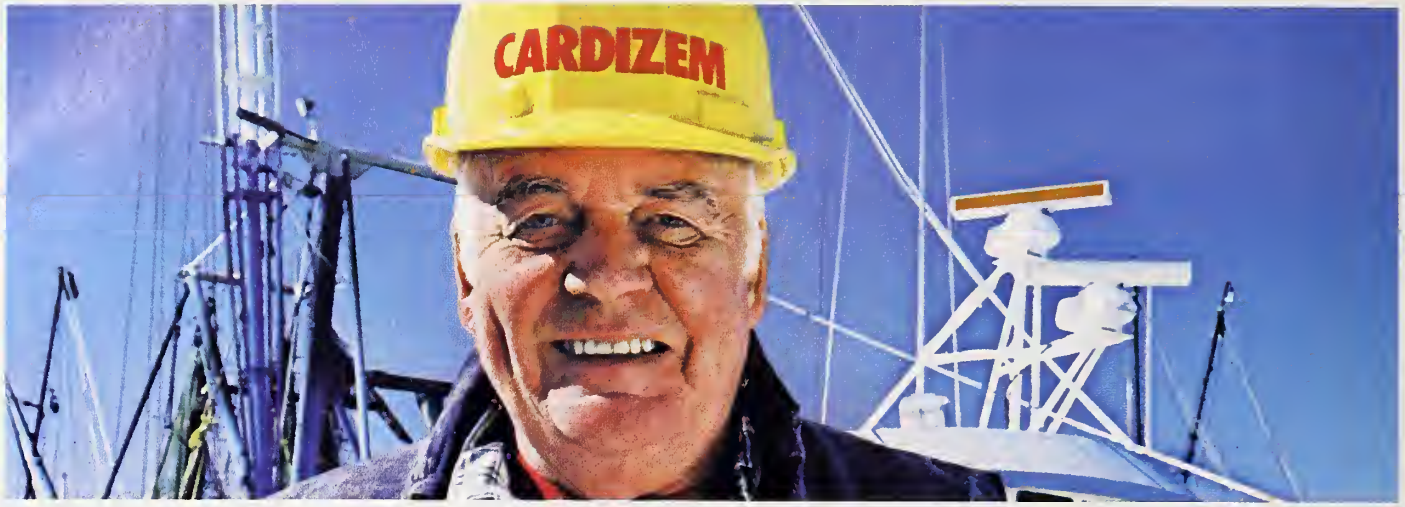


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CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

**WARNINGS**

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

**PRECAUTIONS**

**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

**Drug Interaction.** Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

**Pediatric Use.** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS**

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

| | |
|---|---|
| Cardiovascular: | Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope. |
| Nervous System: | Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor. |
| Gastrointestinal: | Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase. |
| Dermatologic: | Petechiae, pruritus, photosensitivity, urticaria. |
| Other: | Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties. |

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# Progressive Dyspnea and Pulmonary Edema in an Obese Somnolent Man

Bashir A. Chaudhary, M.D., Tesneem K. Chaudhary, M.D., William A. Speir, M.D.

A 26-YEAR-OLD MAN, weighing 405 pounds, was seen at the Medical College of Georgia Hospital for evaluation of progressive shortness of breath and daytime somnolence.

*History*

The patient gave a history of progressive exertional dyspnea, 2 pillow orthopnea, and paroxysmal nocturnal dyspnea for the past 7 years. He had very restless sleep and had awakened innumerable times from sleep because of shortness of breath. During the day, he had headaches, felt drowsy, and many times would fall asleep during his work as a mechanic. He had been treated with methylphenidate for his daytime somnolence without improvement. He had been admitted to his local hospital with severe shortness of breath and respiratory failure. Admission chest roentgenogram showed bilateral pulmonary edema (Figure 1). He rapidly improved with intubation and mechanical ventilation. His symptoms, however, continued after discharge from the hospital. The patient had gained 70 pounds during the previous 6 months despite vigorous diuretic therapy with furosemide (80 mg daily).

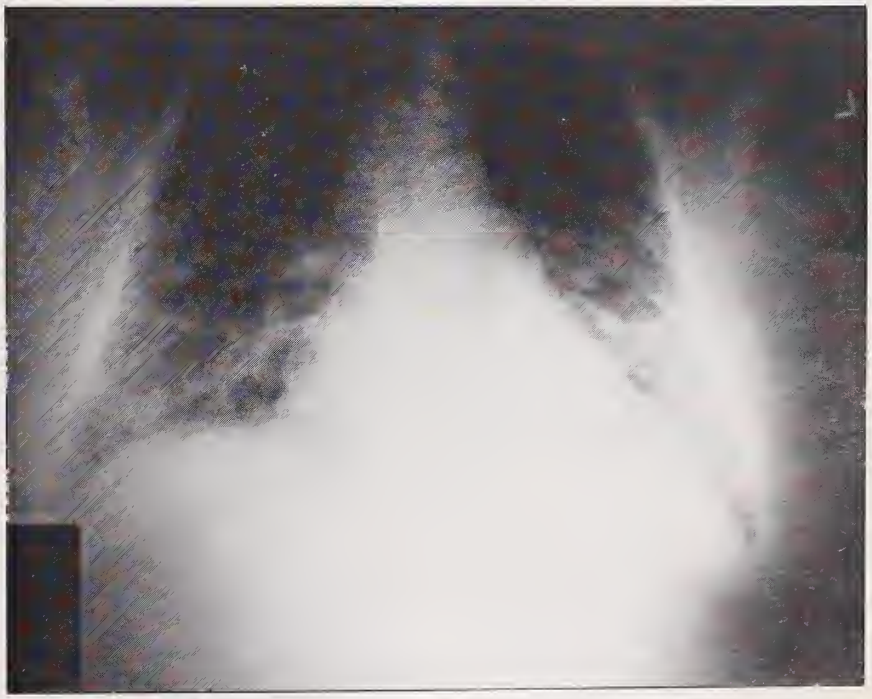

*Figure 1 — Admission chest roentgenogram showing bilateral pulmonary edema.*

*Physical Examination*

Physical examination was remarkable for obesity, bilateral tonsillar enlargement, enlarged uvula and uvulopalatal fold, and pitting edema of the legs. An arterial blood gas analysis showed: pH 7.46, PaO2 48 mmHg, PaCO2 53 mmHg, and HCO3 36 mEq/L.

From the Section of Pulmonary and Critical Care Medicine and Section of Allergy and Immunology, Medical College of Georgia, Augusta. Send reprint requests to Dr. Bashir A. Chaudhary, Associate Professor of Medicine, Section of Pulmonary and Critical Care Medicine, Department of Medicine, MCG, Augusta, GA 30912.

The paper was sponsored by the Georgia Thoracic Society.

*Diagnosis*

Acute pulmonary edema secondary to sleep apnea.

Because of a history of progressive shortness of breath, restless sleep, morning headaches, and daytime somnolence, the possibility of sleep apnea was considered.

A 5-hour nocturnal polysomnogram consisting of electroencephalogram, electrocardiogram, chest wall and abdominal expansion, oronasal airflow, and oxygen saturation was performed (Figure 2). The patient spent 3.65 hours in sleep state. There were 447 apneic episodes ranging in duration from 10-47 seconds; the mean apneic duration was 15.7 seconds. The apnea index (number of apneic episodes per sleep hour) was 122, and the patient spent 53.5% of his sleep time in an apneic state. All apneic episodes were obstructive in type, i.e., chest wall and abdominal expansion continued during cessation of oronasal airflow. The oxygen saturation as measured by ear oximetry repeatedly fell with apneic episodes, and values of less than 20 percent were recorded.

The patient's symptoms improved following tonsillectomy and during the 2 years of follow up, the patient has not had daytime somnolence or nocturnal dyspnea. Chest roentgenograms have remained normal.

*Comments*

Sleep apnea syndrome is characterized by obesity, daytime hypersomnolence, snoring, pulmonary hypertension, and episodes of cessation of breathing at night.[1,2] We recently reported two other cases of acute pulmonary edema occurring because of obstructive sleep apnea.[3,4] In this case report, we describe the third patient who had acute pulmonary edema and was found to have obstructive sleep apnea. The finding of three cases of pulmonary edema due to sleep apnea at the same institution suggests that this association may not be uncommon. Symptoms of sleep apnea should be sought in all obese patients who present with repeated episodes of shortness of breath or the suggestion of pulmonary edema on a chest roentgenogram, particularly if there is no obvious cardiovascular abnormality.

The mechanism of pulmonary edema in patients with obstructive

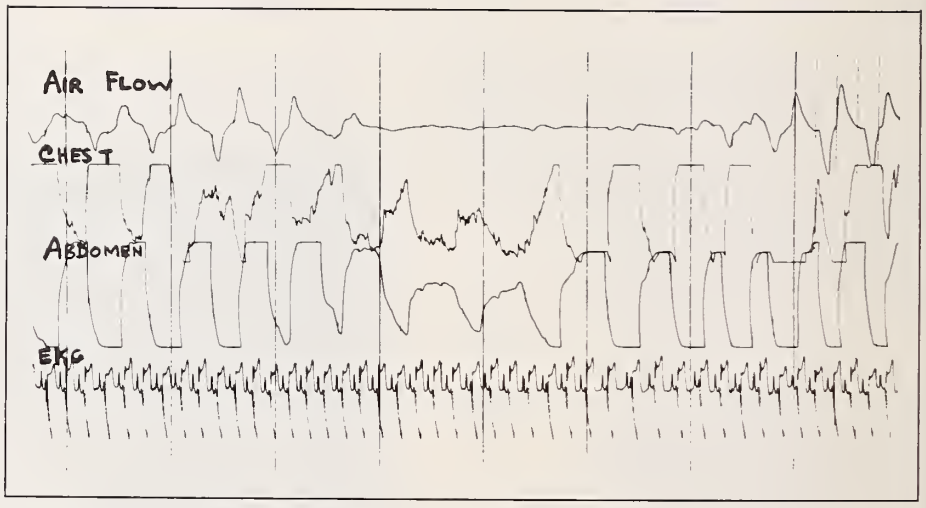


*Figure 2 — Polysomnogram showing airflow at the mouth and nostrils, chest movements, abdominal movements, and ECG. A 30-second obstructive apneic episode is shown.*

***"Symptoms of sleep apnea should be sought in all obese patients who present with repeated episodes of shortness of breath or the suggestion of pulmonary edema on a chest roentgenogram, particularly if there is no obvious cardiovascular abnormality."***

sleep apnea syndrome is not known. Pulmonary edema has been described in patients with acute upper airway obstruction.[5] The possible mechanisms of pulmonary edema in these patients include extreme negative intrathoracic pressure, hypoxemia, pulmonary hypertension, and endogenous production of opiates.

Extremely high negative intrathoracic pressure may occur during attempted inspirations when there is upper airway obstruction.[6] This negative intrathoracic pressure may favor exudation of fluid from the capillaries into the interstitium. Re-expansion pulmonary edema probably occurs because of negative intrathoracic pressure after rapid suction of pleural effusion or pneumothorax.

Episodes of extreme hypoxemia occurring during apneic episodes may cause many cardiovascular abnormalities.[7] Nocturnal arrhythmias and systemic hypertension may lead to left ventricular dysfunction. In our three patients, continuous cardiac monitoring and frequent blood pressure measurements did not reveal any significant abnormality. The possibility, however, remains that arrhythmias and/or elevation of arterial blood pressure might have occurred on the nights when the pulmonary edema developed.

Extreme elevation of pulmonary artery pressure may occur in these patients. Pulmonary artery pressure in one of our patients with pulmonary edema and sleep apnea was 44/22 mmHg at rest but increased to 152/70mmHg during apneic episodes.[4] Pulmonary hypertension may contribute to pulmonary edema by increasing pulmonary lymph flow, impairing the lymph return to systemic circulation and possibly reducing the blood return from bronchial vessels.[4]

Opiate overdoses have been known to cause pulmonary edema. Endogenous production of opiates in patients with obstructive sleep apnea may cause pulmonary edema.[8] Hypoxemia has been shown to stimulate endogenous opiates production, and a decrease in apneic episodes in rabbits has been shown following naloxone therapy.[9]

***“Extremely high negative intrathoracic pressure may occur during attempted inspirations when there is upper airway obstruction.”***

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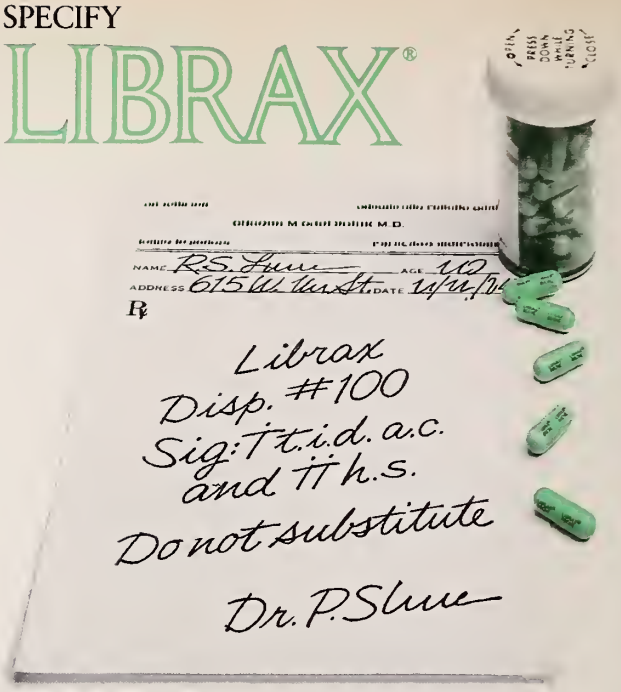


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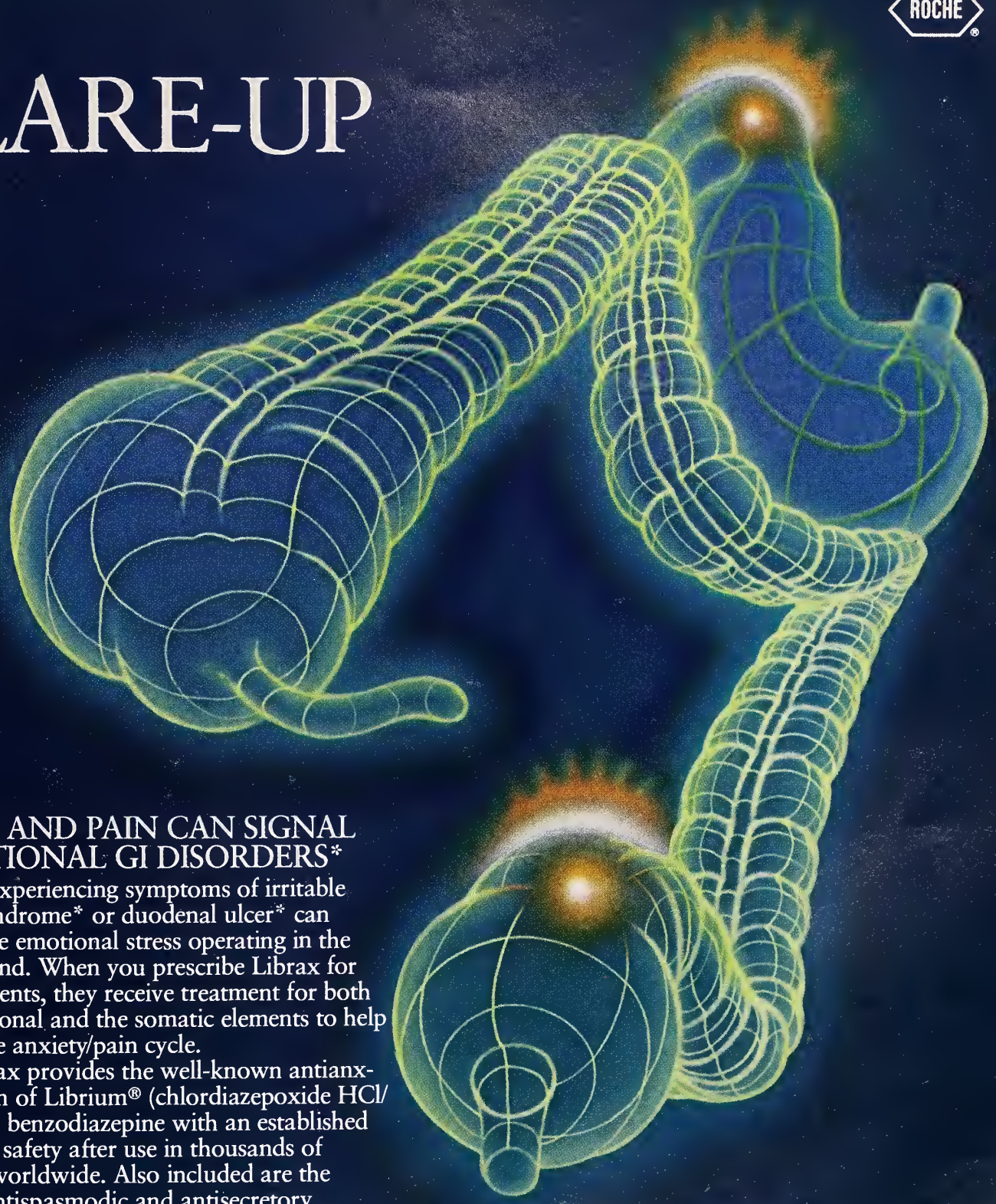

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# Hospital Peer Review in a Hostile Environment

*Richard Greene*

HOSPITAL MEDICAL STAFFS are increasingly reticent about conducting meaningful peer review when their actions may result in the need to limit or withdraw a staff member's privileges. In light of the recent *Patrick vs. Burget*[1] decision in the Ninth Circuit of the U.S. Court of Appeals and similar cases, such concerns by medical staff physicians have substantial basis in fact.

A physician or other health care provider who is denied hospital privileges or otherwise disciplined by a peer review committee will often seek out every possible legal avenue available to fight the sanction. Available weapons in his arsenal include legal actions in both the state and federal court systems. The two major areas of attack have historically been allegations of antitrust activities and the lack of good faith by the individual committee members.

### Background

The *Patrick* case resulted from a peer review committee's activities which lead to the termination of hospital privileges for Dr. Patrick and sanctions by the Oregon Board of Medical Examiners against him. The issue arose in a small community of about 10,000 population where one large doctor group was substantially dominant in the market place. Despite being offered a partnership, Dr. Patrick left this large "dominant" group and set up an independent practice in 1973. These doctors apparently were angry with Dr. Patrick. They allegedly treated Dr. Patrick and his partner with disdain.

Dr. Patrick and a former partner were subsequently charged by members of the dominant group with medical misconduct by mishandling a surgery case. Actions were taken against Dr. Patrick's local hospital privileges as well as his state medical license. The Court records showed numerous examples of unequal treatment and unequal application of the peer review process by the dominant group. One physician, who was not disciplined, could not complete a surgery procedure due to an apparent alcohol-related breakdown. That physician, at the time, rented space from the large group and received many patient referrals from them. On the other hand, Dr. Patrick was disciplined for a much lesser alleged offense. The dominant group sent surgery patients to three hospitals 50 miles away in order to prevent Dr. Patrick from seeing them. There were allegations of attempts to "steal" Dr. Patrick's patients. "The pattern of treatment of emergency room patients suggested that the group doctors were attempting to make Patrick's patients their own and to prevent new ones from seeing him. Witnesses testified that they had come to the emergency room, asked for Dr. Patrick, and were told he was not available. Later, they discovered that Patrick was available and no attempt had been made to contact him." The large group doctors contended that their reluctance to deal with Dr. Patrick was due to his lack of skill, yet there was a great amount of testimony that Dr. Patrick was a very good surgeon.

### Antitrust Allegations

Antitrust allegations have been the most difficult to deal with by physician peer review committees throughout the country. The sanctioned physician's normal accusation is that the sanction was one imposed by his or her competitors for their monetary gain and to the economic detriment of the sanctioned provider. The defendant peer review committee usually responds that their actions were primarily for the protection of patients and quality medical care, and secondly, that they are immune from suit under federal and state statutes[2] and public policy. The Sherman Antitrust Act is usually cited to bring the actions before the U.S. courts. The *Patrick* case and a recent letter issued

Mr. Greene is MAG's General Counsel. Direct inquiries to him at 938 Peachtree St., Atlanta, GA 30309; PH:404-876-7535; or WATS in Georgia, 800-282-0224.

y the U.S. Department of Justice[3] go long way in settling major portions f the antitrust agreements.

***“The* Patrick *case esulted from a peer review ommittee's activities vhich lead to the ermination of hospital rivileges for Dr. Patrick nd sanctions by the Oregon Board of Medical Examiners against im.”***

The *Patrick* Court recognized that ie peer review process ‘‘allows octors to agree to eliminate a ompetitor from the marketplace ecause they believe his or her product s substandard.’’ Peer review in the ompetitive sense is like allowing ieneral Motors, Chrystler, or Ford to eview the safety and quality of nported automobiles to determine if ie public should be allowed to drive iem on our highways. Therefore, it is asy to understand the reason for the umerous legal struggles surrounding ntitrust issues. State and federal ublic policy is prevailing, however, on the side of upholding the concept of peer review. Recent court and aaministrative decisions, as well as the ‘‘Health Care Quality Improvement Act’’ signed by President Reagan on November 14, 1986, set out the proposition that legitimate peer review committee activities should no longer be subject to antitrust claims. The Justice Department letter stated in part, ‘‘it would be most unfortunate if physicians refrained from participating in hospital peer review activity because of unwarranted fear that such participation was likely to pose serious concerns under the antitrust laws.’’ The letter, which was written in December, 1986, after enactment of the ‘‘Health Care Quality Improvement Act,’’ points out that immunity is clearly provided to those groups and individuals that conduct peer review according to fair procedures and provide standards for review. The Justice Department's letter further stated, ‘‘. . . only in the exceptional circumstances where the peer review process is not used to review individual competence, but rather is a sham used to exclude a competent practitioner or a group of practitioners from the market and thus restrain competition, would a violation ever exist.’’ The letter does not bind a court of law in an individual case, but clearly enhances a defense by showing the U.S. Government's policy stated that since ‘‘. . . peer review enhances both the quality and efficiency of services delivered in our nation's hospitals to the benefit of the consumer, it furthers the antitrust goal of fostering competition in the health care marketplace.’’

### Lack of Good Faith

The *Patrick* case and other court and administrative decisions are making it much more reassuring for the physician to rely upon statutory immunity, but only if he acts in ‘‘good faith.’’ ‘‘Good Faith’’ immunity means that a provider can be involved in the process of limiting the activities of a competitor providing a

***‘‘‘Good Faith’ immunity means that a provider can be involved in the process of limiting the activities of a competitor providing a ‘substandard product.’ Peer review carried out by competitors but in ‘good faith’ and pursuant to fair procedures have been upheld by the courts.’’***

"substandard product." Peer review carried out by competitors, but in "good faith" and pursuant to fair procedures have been upheld by the courts. In the *Patrick* case, the Court found that there "was substantial evidence that the defendants acted in bad faith in the hospital's peer review process. . . ." A sanctioned physician could attempt to show bad faith activities by demonstrating a double standard. The lack of sanctions against the alcoholic physician is an example of such. Although antitrust claims are now being restricted by the courts, a peer review committee member will continue to be subject to legal claims of no statutory immunity because of a lack of good faith.

***"A physician . . . who is denied hospital privileges or otherwise disciplined by a peer review committee will often seek out every possible legal avenue available to fight the sanction."***

### Conclusion

The *Patrick* case ended in a 2.1 million dollar verdict for Dr. Patrick. The Ninth Circuit overturned the verdict, but remanded it back to both the state and federal trial courts for further legal considerations. This remanding occurred despite the courts' finding virtually no actionable antitrust violation and after the broad granting of immunity to the defendant peer review committee members. The lower courts are to consider if any of the actions taken were in "bad faith" and if any of the actions taken by the defendants outside of the peer review process violated antitrust laws.

***"In the* Patrick *case, the Court found that there 'was substantial evidence that the defendants acted in bad faith in the hospital's peer review process. . . .'"***

The *Patrick* case first began festering in 1973. The lawsuit was filed in 1981 after several peer review and state board activities which began in 1979. Numerous legal hearings, protective motions for summary judgment, etc. have filled the court dockets since then. After all these years, it still lives today as an appeal to the U.S. Supreme Court which was filed in January, 1987. Regardless of the legal outcome, all of the parties have been significantly hurt by the years of costly litigation. It is easy to see why the *Patrick* case has had a chilling effect on members of peer review committees.

Georgia physicians' are expressly granted immunity from liability from action taken "without malice" on pe review committees as long as the leg statutory standards are met. Despite Georgia's statutes, the *Patrick* case ruling, the Justice Department's lette and the Health Care Quality Improvement Act, no one can assure physician who is a member of a peer review committee that he or she will not get sued, especially if the aggrieved party is a direct competito It is important that the peer review process in Georgia continue; howeve individual physician members should use caution and consider disqualifyin themselves if they have a possible conflict of interest or other anti-competitive problems.

### Notes

1. *Patrick vs. Burget*, et al. United States Court o Appeals for the Ninth Circuit, Case no. 85-3759 and 4071, decided September 30, 1986.
2. Some relevant Georgia statutes are found in O.C.G.A. 3-1-7-130 thru 143; 43-34-37; 24-9-20; an 50-180-72.
3. Letter sent to AMA in December, 1986, by Mr Charles Rule, Acting Assistant Attorney General.

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# CAPSULES

## Help free your patients from recurrences.

## Daily therapy

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Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

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The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

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Brief Summary

**INDICATIONS AND USAGE:** Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psychosocial difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

**First Episodes** (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

**Recurrent Episodes:**

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

**CONTRAINDICATIONS:** Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

**WARNINGS:** Zovirax Capsules are intended for oral ingestion only.

**PRECAUTIONS: General:** Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

**Drug Interactions:** Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the $F_1$ generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

**Pregnancy:** ***Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies,. the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS — Short-Term Administration:** The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

**Long-Term Administration:** The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

**DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes:** One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

**Chronic suppressive therapy for recurrent disease:** One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

**Intermittent Therapy:** One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

**Patients With Acute or Chronic Renal Impairment:** One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance $\leq 10$ ml/min/1.73/m$^2$.

**HOW SUPPLIED:** Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200"- Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

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*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

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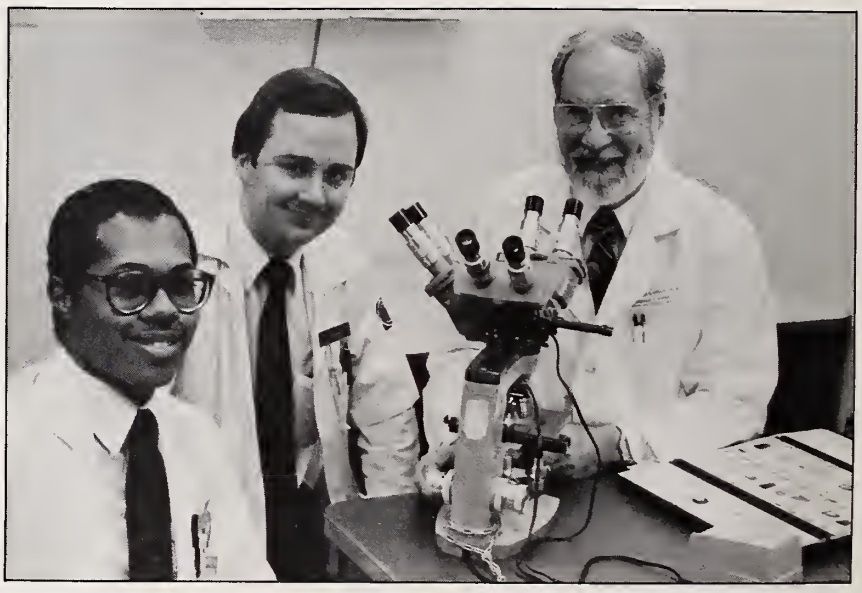
# The Georgia Division Enters Its 41st Year

*Robert E. Knox, Jr.*

THE GEORGIA DIVISION of the American Cancer Society recently celebrated its 40th year of service. The Division has grown from a small gathering of concerned community leaders to a national force in cancer control.

In our 40 years, we have made a tremendous impact upon the citizens of Georgia. When the Georgia Division was first incorporated in 1946, few cancer patients could hope for a cure. Today, more and more patients are returning to full, active, and rewarding lives. The Georgia Division has been at the forefront in this amazing progress. For 40 years, this Division has distinguished itself with vital programs in areas of service and education, and has provided millions of dollars in the continuing search for the answers to the cancer puzzle.

As we enter our 41st year, we take pride in our many accomplishments. Last year, we reached an all time high in our public education efforts with a new education program called "Taking Control." We provided education programs to more health professionals than ever before. And we serviced a record number of cancer patients. The funds we raised during our annual EDUCATION-Funds Crusade will allow us to continue and expand our life-saving efforts.



*Charles Huguley, M.D. (right), Professor of Clinical Oncology at Emory University, trains two of the nine physicians in medical oncology with a grant from the American Cancer Society.*

Shakespeare wrote, "No man can sincerely try to help another without helping himself." We in Georgia are blessed with over 100,000 caring volunteers. The millions of hours put in by these volunteers make possible the many successful programs of the Georgia Division.

Through the commitment and dedication to its volunteers, the Georgia Division carries out its mandate to:

- Educate the public about the prevention and early detection of cancer;
- Provide medical professionals and other health care providers with the most timely information available about the treatment and causes of cancer;
- Provide the best possible service to the 32,000 Georgians who are unde medical care for cancer; and

Mr. Knox is Chairman of the Board of Directors, American Cancer Society, Georgia Division.

This paper was sponsored by the Georgia Division of the American Cancer Society. Those wishing to contribute papers to the CANCER section should send them to Thomas W. Phillips, M.D., CANCER Section Editor, 25 Prescott St., Atlanta, GA 30365.

*Good public education can mean a population better informed against cancer. The Division's Public Education Program teaches thousands of Georgians prevention and early detection of cancer.*

• Move toward the ultimate goal of totally controlling cancer.

In a major step to expand and mprove its programs and services, the )ivision recently purchased a newly enovated building in downtown \tlanta at 46 Fifth Street, between Peachtree and West Peachtree Streets.

This purchase was made possible through a very successful Capital Funds Drive. With over 15,000 square feet of space, the new building is 60% larger than lease space the Division previously occupied. In addition to saving an estimated $75,000 per year in lease payments, the new facility will provide much needed space to implement two new programs — The Cancer Response System and The Childhood Cancer Program.

**The Cancer Response System**

The Cancer Response System will provide a much needed service to the citizens of Georgia. Once in operation, the system will serve as a statewide toll free information hotline to answer the public's questions about cancer. The system will be an effective way of meeting the information and support needs of cancer patients and their families by providing a toll free telephone number. It will address such issues as cancer prevention and early detection, as well as give nonmedical information about cancer sites, treatment, and research.

A major thrust of these services will be a peer support system for patients and their families which will be staffed by volunteers who have cancer or who have recently recovered from cancer.

A simplified information system will also alleviate much of the public's confusion concerning "look-a-like" organizations whose materials are designed to resemble those of the American Cancer Society.

**Childhood Cancer Program**

The Georgia Division's Childhood Cancer Program addresses the very special needs of children with cancer.

*The Service and Rehabilitation Program provides trained volunteers to help cancer patients cope with the frustrations of cancer.*

An expanded program will provide for a support and guidance network of trained volunteers who will be able to assist families who are facing childhood cancer. The newly formed childhood cancer committee of the Georgia Division is addressing childhood cancer issues that include hospice, psychologic impact on long-term survivalship, and education and information networks.

Currently, this program reaches 150 juvenile cancer patients and their families per year. The Division estimates through our expanded efforts we can easily double capacity, thereby potentially serving all of Georgia's children with cancer.

### Service and Rehabilitation Program

In addition to new programs, the Division continues to support and service patients and their families through our Service and Rehabilitation program. The anxieties and frustrations of cancer leave thousands of Georgian cancer patients feeling frightened and alone. These patients and their families face a variety of problems in overcoming cancer and often do not know where to turn for help. The Service and Rehabilitation Program is the heart of the American Cancer Society.

The thousands of Georgia volunteers working with Service and Rehabilitation reflect the true spirit and mission of the American Cancer Society . . . People Helping People. ACS volunteers are always there with a helping hand to insure that life after cancer can be productive and rewarding.

Because many cancer patients are unaware of resources available, the Georgia Division is piloting a resource, information, and guidance community program. Basic to the program is the development of a community resource directory which will provide volunteers readily available referrals throughout the community. The directory will give timely and accurate information about all cancer resources within a local community.

### Other Programs

Meeting the medical needs of the cancer patient is only half the battle. The Division is also prepared to meet the social and emotional requirements of patients. Through education, the patient can learn to cope with cancer. Patient education programs are designed to provide information to patients and their families through established group education seminars and the distribution of pamphlets, booklets, and audio-visual presentations. Group programs, such as "I Can Cope," provide information on the disease of cancer, treatment and side effects, nutrition, and the patient's emotional adaptation to the disease. Of course, the Service and Rehabilitation program always works in close cooperation with the physician and does not give medical advice.

***"Because many cancer patients are unaware of resources available, the Georgia Division is piloting a resource, information, and guidance community program."***

"Reach to Recovery" for breast cancer patients is one of the first and largest of the patient visitation programs. Volunteers, women who have already adjusted successfully to their breast cancer, visit newly diagnosed patients. They serve as proof that women who have had breast cancer can return to active, normal lives. Literature and services are provided to help the husbands, children, and other loved ones of breast cancer patients. Strict confidentiality is maintained in all cases. Physician approval is required for visits to hospitalized patients.

Ostomy Patient Rehabilitation programs are designed to assist persons with an ostomy. The Georgia Division works closely with the United Ostomy Association in helping these individuals make the adjustment after surgery. Trained volunteers offer help on a one-to-one basis. The volunteers work closely with enterostomal therapists who assist in the physical and psychologic rehabilitation of the ostomy patient.

For those who have had a laryngectomy, ACS sponsors laryngectomee clubs which offer help in learning new ways of speaking for laryngectomees. The rehabilitation clubs of the International Association of Laryngectomies play an important role in the rehabilitation of laryngectomy patients. Speech lessons may be included as part of the American Cancer Society program using speech pathologists and trained lay teachers.

Self-help and support groups offer patients and their families the opportunity to share common experiences, frustrations, and successes. Many anxieties can be overcome by learning from others in the same situation. Support groups are conducted under the leadership of a psychologist, nurse, social worker, or other professional counselor or physician.

***"Meeting the medical needs of the cancer patient is only half the battle. The Division is also prepared to meet the social and emotional requirements of patients."***

The Service and Rehabilitation program can provide limited financial support for some pain-relieving drugs for medically indigent patients. The Georgia Division has an approved list of medications. Unfortunately, the American Cancer Society funds cannot be used to pay hospital bills. However, the Division, through its local Units, helps patients find financial support in the community.

These are just a few of the Georgia Division's many services. We will continue to expand and improve our programs. The fifth decade of the Georgia Division holds great promise. With the continued support of the medical community and the general public, we look forward to providing Georgia with the best possible services.

We have accomplished a great deal during the past 40 years, but we know there is still much to be done. The volunteers of the Georgia Division will always be there working to improve the quality of life for all who are touched by cancer.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WOODRIDGE HOSPITAL

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Phone (404) 782-3100

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## 'ERSONALS

*'ifth District*

**Stanley Levine, M.D.,** chief of ediatrics at The Medical Center, was ppointed to the Muscogee County 3oard of Education.

**Robert F. Finegan, M.D.,** a ardiologist from East Point, has eceived a bronze medal from the Georgia Heart Association for his work on life support systems.

**Eileen Niren, M.D.,** has joined the staff of North Fulton Medical Center in the practice of dermatology and dermatological surgery.

**W. Dean Warren, M.D.,** of Atlanta, was installed as the 67th President of the American College of Surgeons during Convocation ceremonies at the 72nd Annual Clinical Congress, held in New Orleans last October. Dr. Warren received his AB degree from Dartmouth College in Hanover, New Hampshire, in 1947, graduating Phi Beta Kappa. He received his 2-year medical college certificate from Dartmouth in 1948, and his MD degree in 1950 from the Johns Hopkins University School of Medicine, Baltimore, graduating Alpha Omega Alpha.

After completing his postgraduate studies in 1955, Dr. Warren joined the faculty of the University of Virginia in Charlottesville, where he initiated research on surgery for portal hypertension and in 1956 was awarded a Markle Scholarship. In 1960, he spent the spring and summer in research at the Institute for Experimental Surgery and the Rigshospitalet of the University of Copenhagen as a part of his Markle program. His research on portal hypertension (usually associated with liver disease) became his primary interest while he was at Charlottesville.

In 1963, he accepted the position of professor and chairman of the department of surgery at the University of Miami School of Medicine, Coral Gables, FL. During his 8-year-tenure there, he also served as dean and vice-president for Medical Affairs for more than two years. In 1971, he accepted his current appointment as the Joseph Brown Whitehead Professor and chairman of the department of surgery at Emory University in Atlanta.

*W. Dean Warren, M.D., of Atlanta, is the 67th President of the American College of Surgeons.*

Dr. Warren is a member of more than 20 medical societies and has been president of American Surgical Association. A Fellow of the College since 1959, he has held a number of leadership positions with the College. He was a member of the Board of Regents from 1976 to 1985, and served as the Vice-Chairman of the Board from 1984 to 1985. In October, 1985, Dr. Warren became President-elect of the college. He had served on the editorial boards of the journals *Surgery, American Journal of Surgery,* and *Surgery, Gynecology, and Obstetrics*. In addition, Dr. Warren has authored more than 160 publications since 1952.

*Eighth District*

**Frank Blaydes, M.D.,** has opened his first office for family medicine in Lake Park. He attended the Medical College of Georgia, graduating in 1983 and completed his family practice residency there in 1986.

**Ollie O. McGahee, Jr., M.D.,** a family physician in Jesup, was recently honored with the Distinguished Service Award presented at the Annual Scientific Assembly of the Georgia Academy of Family Physicians in Atlanta.

Dr. McGahee has been active in the Academy since he became a member in 1961 and has served in every officer capacity including Past President. He also serves on the State Medical Education Board and was instrumental in the formation of the Joint Board of Family Practice. Dr. McGahee is an educator and was honored as Family Practice of the year in 1985 for his involvement in the preceptorship program at MCG.

*Tenth District*

**Pablo Piedrahita, M.D.,** of Rockdale County, became a Fellow of the American College of Surgeons during recent ceremonies at the Association's annual Clinical Congress.

**Paul McDonough, M.D.,** of Augusta, has been elected president of the Society of Reproductive Endocrinologists. He is chief of the section of reproductive endocrinology at the Medical College.

**Ramesh K. Srivastava, M.D.,** a plastic surgeon, has joined the medical staff of the Cobb Memorial Hospital and nursing home.

## DEATHS

**Cheney C. Sigman, Jr., M.D.,** an allergy and pediatrics specialist, died at the age of 59 on December 7 in Athens.

Dr. Sigman attended Emory University as an undergraduate student and also received his medical degree there. He interned at Tulane University and did his residency at the University of Michigan at Ann Arbor. During World War II he was a member of the armed forces and continued college after the War's end. He was a member of the American Medical Association, the American Academy of Pediatrics, American Association of Allergists, and the American College of Allergists. He is survived by his wife and four children.

**John Cummings Withington, M.D.,** who practiced medicine in Savannah for 38 years before he retired last June, died after a long illness.

Dr. Withington was a graduate of Riverside Military Academy, Duke University and Duke University Medical College. He received his medical degree from Duke in 1946. He served his internship at Grady Memorial Hospital in Atlanta and residencies at Grady Memorial and Emory University Hospitals in Atlanta. He was on the staff of Candler General and Memorial Center. He is survived by his wife and four children.

## QUOTES

*Do not love your neighbor as yourself. If you are on good terms with yourself, it is an impertinence; if on bad, an injury.*
GEORGE BERNARD SHAW

*True affection is a body of enigmas, mysteries and riddles, wherein two so become one that they both become two.*
THOMAS BROWNE

*Many promising reconciliations have broken down because, while both parties came prepared to forgive, neither party came prepared to be forgiven.*
CHARLES WILLIAMS

*Capable assistants keep us in balance, and from underjudging or overestimating the importance of many things.*
WILLIAM FEATHER

*A great man shows his greatness by the way he treats little men.*
THOMAS CARLYLE

*An enthusiast may bore others — but he has never a dull moment himself.*
JOHN KIERAN

*To defy external forces, to rise above circumstances, is to proclaim the sovereignty of the human spirit.*
CHAIM WEIZMANN

*The only new ideas that are not subject to our skepticism or suspicion are our own.*
CULLEN HIGHTOWER

*My belief is that to have no wants is divine.*
SOCRATES

*Human beings do not do all the evil of which they are capable.*
HENRI DE MONTHERLANT

*The best cure for an off day is a day off.*
FRANK TYGER

*A pleasure is none the less a pleasure because it does not last forever.*
W. SOMERSET MAUGHAM

*Those whom you can make like themselves better will, I promise you, like you very well.*
LORD CHESTERFIELD

Source: *Forbes*

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

**WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

**Contraindications:** Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings:** **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum $K^+$ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict $K^+$ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

**Precautions:** The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

**Supplied:** **'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.**

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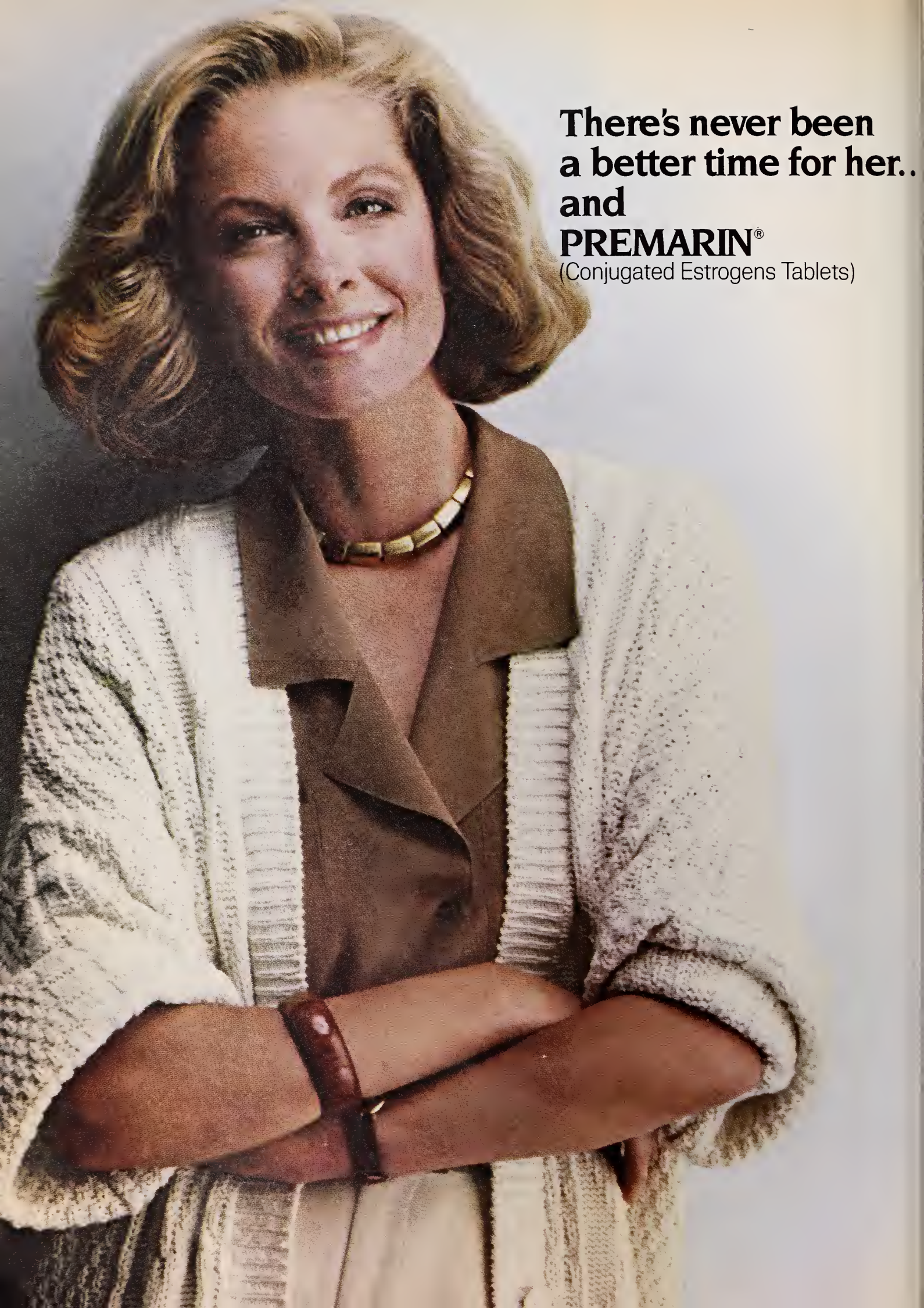
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and
PREMARIN®
(Conjugated Estrogens Tablets)

# Now the evidence looks better than ever

## Significantly reduced risk of endometrial hyperplasia

Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month.[1-4] The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

## Effect on lipids—an important feature

PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.[5]

## Low-dose control of menopausal symptoms*

PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

## The most widely used, most extensively studied estrogen worldwide.

# PREMARIN®

(Conjugated Estrogens Tablets)

**Most trusted for more reasons**

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

# For moderate-to-severe vasomotor symptoms

# PREMARIN®
## (Conjugated Estrogens Tablets)

0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

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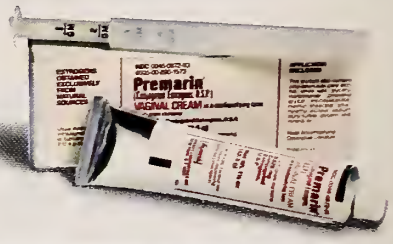
# For atrophic vaginitis

# PREMARIN®
## (Conjugated Estrogens)

Vaginal Cream

0.625mg/g




BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

**PREMARIN® Brand of conjugated estrogens tablets, USP**
**PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base**

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA.

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.
2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.
The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

**DESCRIPTION:** PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

**INDICATIONS AND USAGE:** PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

**Concomitant Progestin Use:** The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

**CONTRAINDICATIONS:** Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

**WARNINGS:** Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

**PRECAUTIONS:** Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.
b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.
c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.
d. Impaired glucose tolerance.
e. Decreased pregnanediol excretion.
f. Reduced response to metyrapone test.
g. Reduced serum folate concentration.
h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

**ADVERSE REACTIONS:** The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

**ACUTE OVERDOSAGE:** May cause nausea, and withdrawal bleeding may occur in females.

**DOSAGE AND ADMINISTRATION:**

**PREMARIN® Brand of conjugated estrogens tablets, USP**

1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.
2. *Given cyclically:* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis —0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

**PREMARIN® Brand of conjugated estrogens Vaginal Cream**

*Given cyclically for short-term use only.* For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

**References:**

**1.** Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605 **2.** Paterson MEL, Wade-Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824. **3.** Magos AL, Brincat M, Studd JWW, et al: Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985; 67: 496-499. **4.** Whitehead MI, Lane G, Siddle N, et al: Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women. *Semin Reprod Endocrinol* 1983;1:1;41-52. **5.** Barnes RB, Roy S, Lobo RA: Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219.

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# ADVERTISING INDEX


Air Force Reserve ..... 84

American Cancer Society ..... 105, 108

American Heart Association ..... 96, 123, 140

Arthritis Foundation ..... 106

Atlanta Magnetic Imaging ..... 92

Ayerst Laboratories ..... 116A-D, 148B-D

Brawner Psychiatric Institute ..... 90

Burroughs Wellcome ..... 141, 140A, B

Classifieds ..... 124

CPC Parkwood Hospital ..... 116

Data Plus Corporation ..... 88

Health Quip, Inc. ..... 92

Knoll Pharmaceutical ..... 84A, B

Lilly, Eli & Company ..... 92A, B

MAG Mutual Insurance Company ..... 82

Marion Laboratories, Inc. ..... 132A, B

Medic Computer Systems ..... 149

Medical Defense Corporation ..... 93

M$NY Credit Corp. ..... 107

Neuropsychiatric Diagnostic Clinic of Atlanta ..... 83

Ridgeview Adolescent Program ..... 105, 107, 109

Roche Laboratories ..... 136, 137, 151, 152

St. Joseph's Hospital ..... 136

St. Jude Children's Research Hospital ..... 110

Stuart James ..... 92

Smith Kline and French Labs ..... 148A

Upjohn Company ..... 92A, B

Weight Watchers of Greater Atlanta ..... 107

Woodridge Hospital ..... 145


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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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MARCH 1987

# JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

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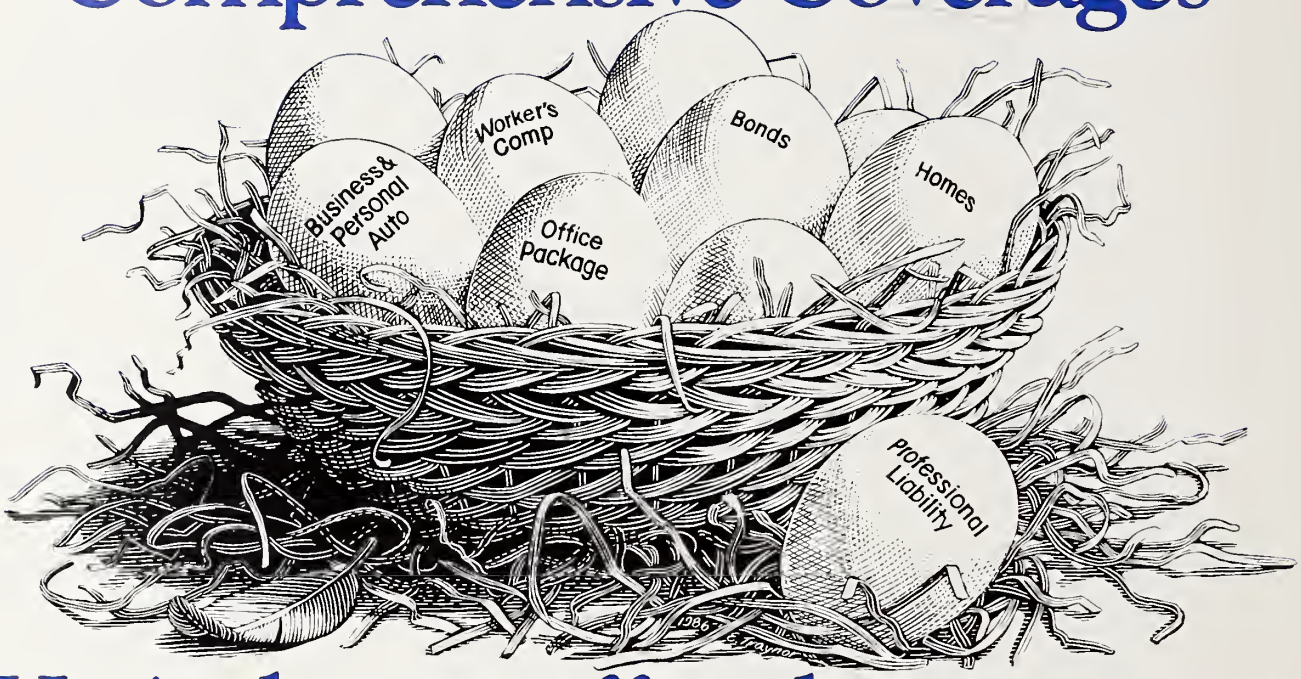


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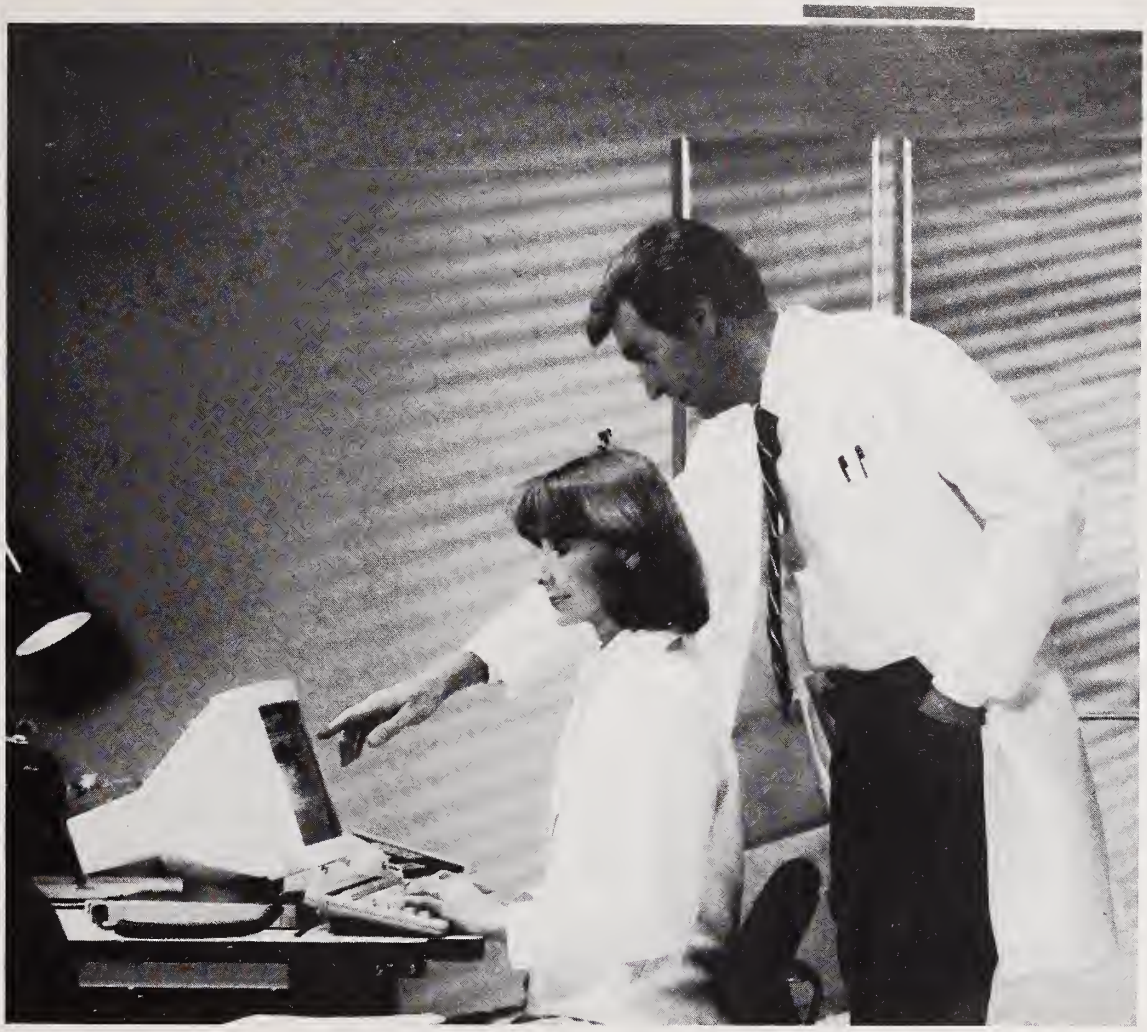

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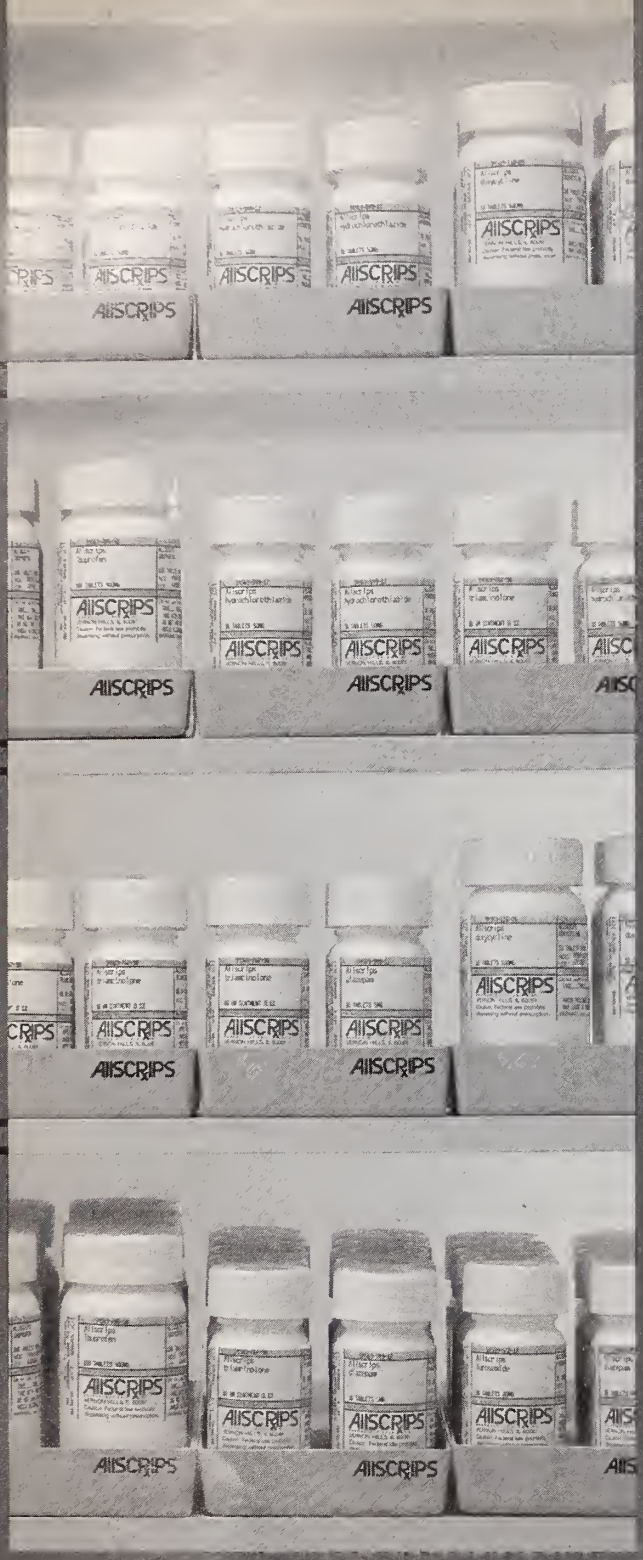


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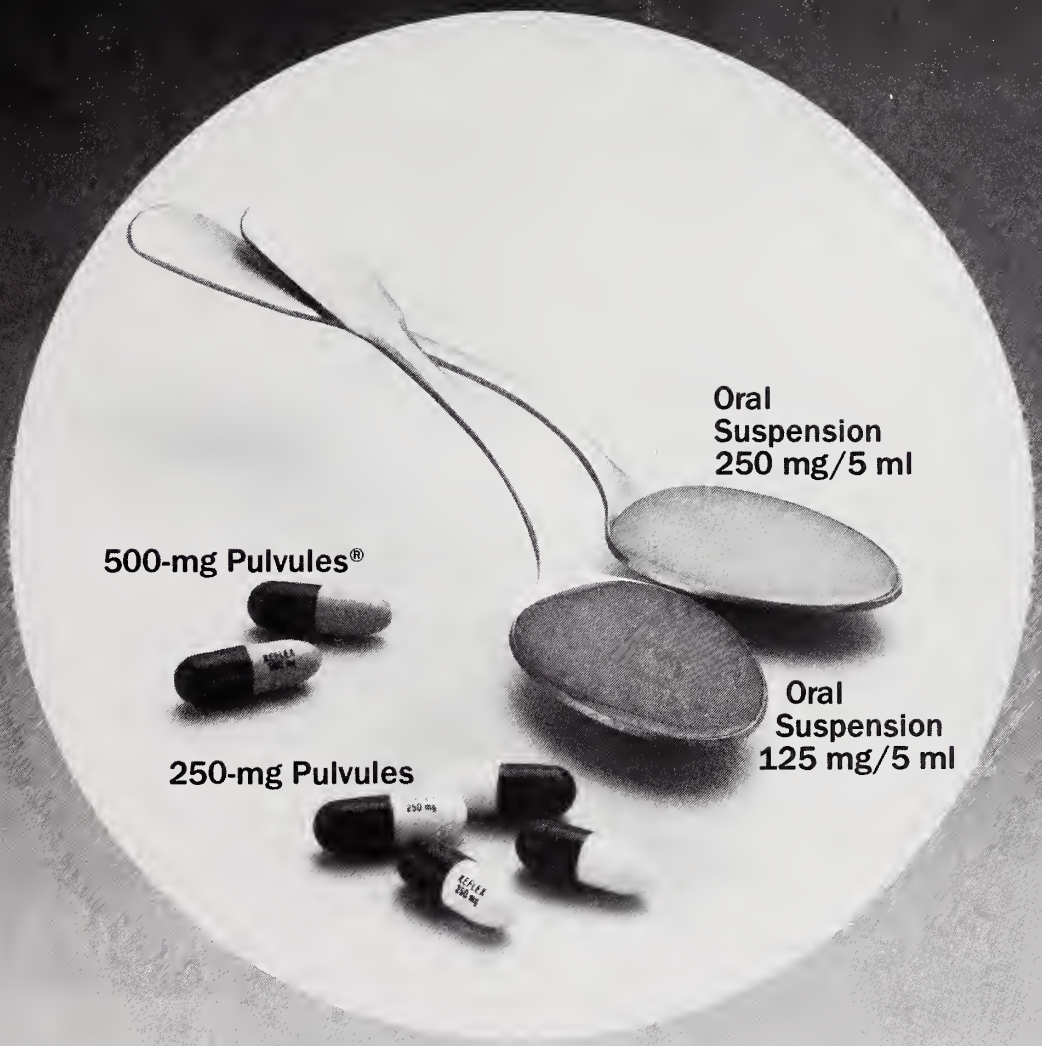


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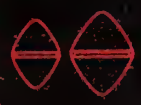

## SYNCHRONIZED SULFONYLUREA THERAPY

*Please see brief summary of Glucotrol® (glipizide) prescribing information on next page.*

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Reference:
1. Sachs R, Frank M, Fishman SK: Overview of clinical experience with glipizide. In *Glipizide: A Worldwide Review*. Princeton, NJ, Excerpta Medica, 1984, pp 163-172.

**GLUCOTROL® (glipizide) Tablets**

**Brief Summary of Prescribing Information**

**INDICATIONS AND USAGE:** GLUCOTROL is indicated as an adjunct to diet for the control of hyperglycemia in patients with non-insulin-dependent diabetes mellitus (NIDDM, type II) after an adequate trial of dietary therapy has proved unsatisfactory.

**CONTRAINDICATIONS:** GLUCOTROL is contraindicated in patients with known hypersensitivity to the drug or with diabetic ketoacidosis, with or without coma, which should be treated with insulin.

**SPECIAL WARNING ON INCREASED RISK OF CARDIOVASCULAR MORTALITY: The administration of oral hypoglycemic drugs has been reported to be associated with increased cardiovascular mortality as compared to treatment with diet alone or diet plus insulin. This warning is based on the study conducted by the University Group Diabetes Program (UGDP), a long-term prospective clinical trial designed to evaluate the effectiveness of glucose-lowering drugs in preventing or delaying vascular complications in patients with non-insulin-dependent diabetes. The study involved 823 patients who were randomly assigned to one of four treatment groups (*Diabetes*, 19, supp. 2:747-830, 1970).**

**UGDP reported that patients treated for 5 to 8 years with diet plus a fixed dose of tolbutamide (1.5 grams per day) had a rate of cardiovascular mortality approximately 2-1/2 times that of patients treated with diet alone. A significant increase in total mortality was not observed, but the use of tolbutamide was discontinued based on the increase in cardiovascular mortality, thus limiting the opportunity for the study to show an increase in overall mortality. Despite controversy regarding the interpretation of these results, the findings of the UGDP study provide an adequate basis for this warning. The patient should be informed of the potential risks and advantages of GLUCOTROL and of alternative modes of therapy.**

**Although only one drug in the sulfonylurea class (tolbutamide) was included in this study, it is prudent from a safety standpoint to consider that this warning may also apply to other oral hypoglycemic drugs in this class, in view of their close similarities in mode of action and chemical structure.**

**PRECAUTIONS: Renal and Hepatic Disease:** The metabolism and excretion of GLUCOTROL may be slowed in patients with impaired renal and/or hepatic function. Hypoglycemia may be prolonged in such patients should it occur.

**Hypoglycemia:** All sulfonylureas are capable of producing severe hypoglycemia. Proper patient selection, dosage, and instructions are important to avoid hypoglycemia. Renal or hepatic insufficiency may increase the risk of hypoglycemic reactions. Elderly, debilitated or malnourished patients and those with adrenal or pituitary insufficiency are particularly susceptible to the hypoglycemic action of glucose-lowering drugs. Hypoglycemia may be difficult to recognize in the elderly or people taking beta-adrenergic blocking drugs. Hypoglycemia is more likely to occur when caloric intake is deficient, after severe or prolonged exercise, when alcohol is ingested, or when more than one glucose-lowering drug is used.

**Loss of Control of Blood Glucose:** A loss of control may occur in diabetic patients exposed to stress such as fever, trauma, infection or surgery. It may then be necessary to discontinue GLUCOTROL and administer insulin.

**Laboratory Tests:** Blood and urine glucose should be monitored periodically. Measurement of glycosylated hemoglobin may be useful.

**Information for Patients:** Patients should be informed of the potential risks and advantages of GLUCOTROL, of alternative modes of therapy, as well as the importance of adhering to dietary instructions, of a regular exercise program, and of regular testing of urine and/or blood glucose. The risks of hypoglycemia, its symptoms and treatment, and conditions that predispose to its development should be explained to patients and responsible family members. Primary and secondary failure should also be explained.

**Drug Interactions:** The hypoglycemic action of sulfonylureas may be potentiated by certain drugs including nonsteroidal anti-inflammatory agents and other drugs that are highly protein bound, salicylates, sulfonamides, chloramphenicol, probenecid, coumarins, monoamine oxidase inhibitors, and beta adrenergic blocking agents. *In vitro* studies indicate that GLUCOTROL binds differently than tolbutamide and does not interact with salicylate or dicumarol. However, caution must be exercised in extrapolating these findings to a clinical situation. Certain drugs tend to produce hyperglycemia and may lead to loss of control, including the thiazides and other diuretics, corticosteroids, phenothiazines, thyroid products, estrogens, oral contraceptives, phenytoin, nicotinic acid, sympathomimetics, calcium channel blocking drugs, and isoniazid. A potential interaction between oral miconazole and oral hypoglycemic agents leading to severe hypoglycemia has been reported. Whether this interaction also occurs with the intravenous, topical, or vaginal preparations of miconazole is not known.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** A 20-month study in rats and an 18-month study in mice at doses up to 75 times the maximum human dose revealed no evidence of drug-related carcinogenicity. Bacterial and *in vivo* mutagenicity tests were uniformly negative. Studies in rats of both sexes at doses up to 75 times the human dose showed no effects on fertility.

**Pregnancy:** Pregnancy Category C: GLUCOTROL (glipizide) was found to be mildly fetotoxic in rat reproductive studies at all dose levels (5-50 mg/kg). This fetotoxicity has been similarly noted with other sulfonylureas, such as tolbutamide and tolazamide. The effect is perinatal and believed to be directly related to the pharmacologic (hypoglycemic) action of GLUCOTROL. In studies in rats and rabbits no teratogenic effects were found. There are no adequate and well controlled studies in pregnant women. GLUCOTROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Because recent information suggests that abnormal blood glucose levels during pregnancy are associated with a higher incidence of congenital abnormalities, many experts recommend that insulin be used during pregnancy to maintain blood glucose levels as close to normal as possible.

**Nonteratogenic Effects:** Prolonged severe hypoglycemia has been reported in neonates born to mothers who were receiving a sulfonylurea drug at the time of delivery. This has been reported more frequently with the use of agents with prolonged half-lives. GLUCOTROL should be discontinued at least one month before the expected delivery date.

**Nursing Mothers:** Since some sulfonylurea drugs are known to be excreted in human milk, insulin therapy should be considered if nursing is to be continued.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:** In controlled studies, the frequency of serious adverse reactions reported was very low. Of 702 patients, 11.8% reported adverse reactions and in only 1.5% was GLUCOTROL discontinued.

**Hypoglycemia:** See PRECAUTIONS and OVERDOSAGE sections.

**Gastrointestinal:** Gastrointestinal disturbances, the most common, were reported with the following approximate incidence: nausea and diarrhea, one in 70; constipation and gastralgia, one in 100. They appear to be dose-related and may disappear on division or reduction of dosage. Cholestatic jaundice may occur rarely with sulfonylureas: GLUCOTROL should be discontinued if this occurs.

**Dermatologic:** Allergic skin reactions including erythema, morbilliform or maculopapular eruptions, urticaria, pruritus, and eczema have been reported in about one in 70 patients. These may be transient and may disappear despite continued use of GLUCOTROL; if skin reactions persist, the drug should be discontinued. Porphyria cutanea tarda and photosensitivity reactions have been reported with sulfonylureas.

**Hematologic:** Leukopenia, agranulocytosis, thrombocytopenia, hemolytic anemia, aplastic anemia, and pancytopenia have been reported with sulfonylureas.

**Metabolic:** Hepatic porphyria and disulfiram-like alcohol reactions have been reported with sulfonylureas. Clinical experience to date has shown that GLUCOTROL has an extremely low incidence of disulfiram-like reactions.

**Endocrine Reactions:** Cases of hyponatremia and the syndrome of inappropriate antidiuretic hormone (SIADH) secretion have been reported with this and other sulfonylureas.

**Miscellaneous:** Dizziness, drowsiness, and headache have been reported in about one in fifty patients treated with GLUCOTROL. They are usually transient and seldom require discontinuance of therapy.

**OVERDOSAGE:** Overdosage of sulfonylureas including GLUCOTROL can produce hypoglycemia. If hypoglycemic coma is diagnosed or suspected, the patient should be given a rapid intravenous injection of concentrated (50%) glucose solution. This should be followed by a continuous infusion of a more dilute (10%) glucose solution at a rate that will maintain the blood glucose at a level above 100 mg/dL. Patients should be closely monitored for a minimum of 24 to 48 hours since hypoglycemia may recur after apparent clinical recovery. Clearance of GLUCOTROL from plasma would be prolonged in persons with liver disease. Because of the extensive protein binding of GLUCOTROL (glipizide), dialysis is unlikely to be of benefit.

**DOSAGE AND ADMINISTRATION:** There is no fixed dosage regimen for the management of diabetes mellitus with GLUCOTROL; in general, it should be given approximately 30 minutes before a meal to achieve the greatest reduction in postprandial hyperglycemia.

**Initial Dose:** The recommended starting dose is 5 mg before breakfast. Geriatric patients or those with liver disease may be started on 2.5 mg. Dosage adjustments should ordinarily be in increments of 2.5-5 mg, as determined by blood glucose response. At least several days should elapse between titration steps.

**Maximum Dose:** The maximum recommended total daily dose is 40 mg.

**Maintenance:** Some patients may be effectively controlled on a once-a-day regimen, while others show better response with divided dosing. Total daily doses above 15 mg should ordinarily be divided.

**HOW SUPPLIED:** GLUCOTROL is available as white, dye-free, scored diamond-shaped tablets imprinted as follows: 5 mg tablet—Pfizer 411 (NDC 5 mg 0049-4110-66) Bottles of 100; 10 mg tablet—Pfizer 412 (NDC 10 mg 0049-4120-65) Bottles of 100.

**CAUTION:** Federal law prohibits dispensing without prescription.

**More detailed professional information available on request.**

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# CONTENTS

VOLUME 76, NUMBER 3

## FEATURES

WE ACHIEVE — COUNTY ACTIVITIES 166

MALPRACTICE SUITS: THEIR EFFECT ON DOCTORS, PATIENTS, AND FAMILIES 171
By Sara C. Charles, M.D.

"YOU *CAN* SAY NO" 173
By Sherry Marsh

CHANGING THE PROFESSIONAL LIABILITY ENVIRONMENT THROUGH GOOD PRACTICE POLICIES 181
By Rachael Blum, J.D.

SAYING "NO" TO SEXUAL INVOLVEMENT 183

THE MEDICAL ASSOCIATION OF GEORGIA HOUSE OF DELEGATES — 1913 186
By Stephen Davis, Ph.D.

THE IMPAIRED PHYSICIAN: THE ROLE OF THE SPOUSE IN RECOVERY 190
By G. Douglas Talbott, M.D.

HIGHLIGHTS OF MAG'S 1987 LEADERSHIP CONFERENCE 193

A-MAG ANNUAL MEETING 196

MEDICAL ASSOCIATION OF GEORGIA HOUSE OF DELEGATES — 1987 198

THE BUSINESS OF LEGISLATION 203
By Jan Collins

## DEPARTMENTS

PRESIDENT'S PAGE 158
AUXILIARY PRESIDENT 159
LETTERS TO THE EDITOR 160
EDITOR'S CORNER 161
EDITORIAL 162
CALENDAR 165
HEART SECTION 206
CANCER SECTION 212
LEGAL SECTION 214
ASSOCIATION NEWS 217
PHYSICIAN'S RECOGNITION AWARD RECIPIENTS 218
AD INDEX/MANUSCRIPT INFORMATION 220

## ABOUT THE COVER

Pablo Picasso's *"Child with a Dove"* was chosen for the cover of this Special Auxiliary issue because it symbolizes the Auxiliary's continued interest in and concern for the children and youth of Georgia. To help them grow and develop into the best individuals they can become, the Auxiliary conducts programs on Teenage Postponing Sexual Involvement, Child Abuse Prevention, Non Use of Tobacco Products, Alcohol and Drug Abuse, and health education directed to the young. The Auxiliary knows the hopes of tomorrow lie in the youth of today.

# *Life Is Not a Spectator Sport!*

THIS BRIEF statement is used by a prominent athletic shoe manufacturer — Reebok — to promote its products. It says so much in so few words. Its broader application really gets the crux of responsible life and the basis of this letter.

We in Medicine represent one of the two remaining learned Professions. It is my opinion that with this attained level of intellect also comes responsibilities which far exceed those of Medicine — desperately needed responsibilities to our communities, our state, and our nation, responsibilities to continue to educate ourselves in issues other than Medicine and to actively participate in those affairs.

We have been trained to rapidly assimilate vast amounts of information, to analyze and conclude a plan of action or make decisions. To perform this task in areas outside of our usual expertise requires some increased effort, which need not be overwhelming. Now, what am I leading to?

I feel we must involve ourselves more actively in the socio-political affairs of our state and nation, or we may well see the destruction of our "American way of life — independence — free-enterprise" due to the continued oppression of governmental social legislation. We have already seen what has happened to our school system, with the production of a generation of poorly educated students. Are we changing it? Very slowly and with great difficulty. Too many good people are sitting back as spectators and letting others determine the course. The goals may be noble, but the process may be totally self-defeating.

Now with the new Congress and new Chairmen, we already see the formidable presence of Senator Kennedy with a proposal for mandated health insurance for all workers. And who is to pay for this? Their employers! With this will there be mandated types of insurance for these employees, with mandated reimbursement fees and other mandates we have not begun to think about? Some believe the next item will be mandated pension plans for all workers under government control. Can you think of placing all of the private pension plans under the Social Security system? This will certainly give a financial boost to a failing system and enable the government deficit to expand more. I believe another term for this is Socialism. You say this can't happen. Look at what has happened to us already.

If you cannot actively become involved in efforts to thwart these plans, at least become educated about them, support groups who can oppose them in your name, be able to inform and influence your elected representatives about them and their dangers. I am not saying it would not be a good idea to have insurance for the medically indigent, but this is not the way to do it. This is nothing but another tax on small business, that they cannot afford, and extends the control and influence of government significantly.

It was once stated, and I will paraphrase, "It only takes the INACTION of a few good men to pass bad laws." You have the intellect and ability to be molders of societal regulation. Will you remain a spectator, or will you come forward in the mature, learned manner of your training and say, "Yes, I will accept the responsibil of my position, my education, and my training to help secure the freedom and independence of the people of my nation. I shall participate to *justly* cure the social ills of our society."

*John D. Watson, Jr., M.D.*

Sincerely,

John D. Watson Jr. M.D.

# /olunteerism Is Not Dead, But Alive, Vell, and Working

ERMA BOMBECK is given credit for ıving written of a dream she had in hich all volunteers were disillusioned y the lack of compassion and ommitment to others which they ound to be prevalent in their own ommunities. In her dream all the olunteers had given up and set sail r another country.

The dreaming Erma saw, as she assed through the town, hospitals here there were no flowers in the atient's rooms; the home for the aged as "like a tomb"; there were people tting in wheel chairs that would ever move and social and health care gencies had closed their doors.

The dream concluded with Erma ghting to get another glimpse of that ip because she knew it was to be the ıst glimpse of civilization as we were ıeant to be.

Had Erma lived in Georgia, her ream might have included no rograms dealing with substance abuse r teenagers postponing sexual ıvolvement; no emphasis on non use f tobacco products, no patient dvocacy programs; no support groups or those involved in malpractice itigation or for battered women or for ne drug impaired. There would have een no child abuse prevention rograms, no health education rograms, no drives to provide for the ndigent and less fortunate. In truth, Erma's dream would have been a very ad state of affairs in Georgia.

But thank goodness, there are over 500 medical auxilians in Georgia who *lo* volunteer work every day to keep hat dream (nightmare?) from ecoming a reality. They are part of he 80,000 medical auxilians working ıll over the nation to provide a better quality of life for everyone.

Mrs. Pat Durham, 1986-87 President of the AMA Auxiliary, stated, "Today's auxiliary member . . . is able to be a part of a powerhouse organization that speaks on behalf of the community and the physicians . . . I say to you, the question is not *why* belong, the question is, can you afford *not* to belong? I think not; I think, rather, we must respect the Auxiliary as the only organization that can help physicians' spouses impact today's changes."

Missouri Governor John Ashcroft's words, "Alone we can but strive; together we can succeed; alone we can but talk, together we can teach; alone we can but act, together we can achieve," were quoted by Mrs. Mary Kay McPhee, Immediate Past President of the AMA Auxiliary in her inaugural address in June of 1985. These words inspired Mrs. McPhee, and she charged auxilians to join with medical societies, other community groups and social service endeavors to work together as a team to provide good health and quality care for everyone.

These same words inspired me and spurred my thoughts and plans for the Auxiliary to the Medical Association of Georgia and from this inspiration came the adaptation for the 1986-87 working theme, "Together We Achieve" — the inference here being not *can* but *do* achieve!

The Auxiliaries, working together with the Medical Societies, seek to provide the leadership medicine must have in this present day world. We recognize that it is necessary to involve intelligent, compassionate, dedicated people — our combined forces — to help shape our society and to help meet its needs. In the "high tech — high touch" world of today, high touch is still vital, we have access to that high touch through our involvement in community services.

*Barbara Tippins (Mrs. William)*
*President, A-MAG*

With these two groups working together our volunteer efforts are numerous and many faceted. We aren't self seeking, nor do we wish to appear to be, we *are* the peoples' advocates.

Medical societies and their auxiliaries give not only of their time, talents, and expertise but also from their hearts with a real desire to "help the family of man make their corners of the world a better place."

Thank you to all medical societies and auxiliaries for caring, thank you for the hours spent in working for the well being of others and thank you for preventing Erma's dream-nightmare from coming true!

*Sincerely,*
*Barbara Tippins*

## Editor Emeritus

Dear Dr. Woody:

"Emeritus" sounds so strange associated to a person such as you who has been so active with your journal and the workings of State Medical Journals Advertising Bureau. I have enjoyed our mutual associations and sincerely hope our paths will cross many times more.

The tributes paid to you in the December 1986 issue of your *Journal* were very nice; well put good words about a great editor.

Best wishes for the future.

Sincerely,
*M. E. Alberts, M.D.*
*Editor*
*Iowa Medicine*

## Smokeless Tobacco

Dear Dr. Richardson:

Thank you for your interest [expressed in a Letter to the Editor in the January, 1987, issue] in the article on Smokeless Tobacco which appeared in the May, 1986, issue of the *JMAG*. I agree with you that the statement, "Smokeless tobacco is the major cause of cancers of the oral cavity, etc" is probably incorrect. Had the word "the" been replaced by the word, "a," I think that the statement would stand as asserting that smokeless tobacco is *a* major cause of cancer of the oral cavity and pharynx in the United States. I must accept responsibility for this error, for I find that the material was printed exactly as I submitted it to the *JMAG*. Certainly there are other very important conditions contributing in the occurrence of cancers in these locations, including smoking tobacco, alcohol and nutritional factors. We do see cancers of the oral cavity and pharynx in many women in this area who do not have the confounding factors of alcohol or smoking tobacco and in whom the use of smokeless tobacco seems almost certainly to be the principal factor contributing to the development of cancer.

That smokeless tobacco is a major cause of cancers of the oral cavity and pharynx in populations where the use of smokeless tobacco is prevalent can hardly be denied and if you accept that view, then you would certainly want to join efforts to discourage the use of smokeless tobacco by young Americans.

Sincerely yours,
*J. T. West, M.D., FACS*
*General Surgeon*
*West Georgia Oncology Associates*
*LaGrange*

## Wagonmaster John and the Leadership Conference

Dear Editor,

Dr. John Watson has made a very appropriate plea for us to "circle the wagons" in his last President's Page, and this was followed up effectively with a good supply of dynamite and gunpowder at the recent MAG Leadership Conference. As a result of such meetings, hopefully we will all be able to better understand the need and method of circling our wagons. But as a minimum benefit, I see the act of circling the wagons as convincing ourselves that we as a profession can act with some unity of purpose and also as giving the enemy some pause over the possibility that we might actually figure out which direction of fire (out vs. in) would do the greatest harm (or "good" depending on one's point of view).

Circling the wagons is in my view, however, only preparatory to that must crucial step in which, for the protection of the patients, we urge them toward the center of the circle we have made for them. Thus, it becomes particularly important that we as defenders get together and mutually decide to do our utmost to head off as early as possible any need for firing at each other and thus to avoid risking danger to the patients at the same time. After all, it is the patients that we are trying to help the most, right?

In poignant illustration of the lesson to be gained from Wagonmaster John's allegory, let's review the unfortunate incident in which Dr. Watson himself was nearly "killed" when his chair fell into a split in the portable stage on which he was sitting while listening to a speech by HHS Inspector General Kusserow on what the government is doing to clean up our profession. Incredulously, that incident happened in the presence of two or three hundred "fellow" physicians, not one of whom ran to his aid (and neither did the Inspector General). John was not hurt fortunately, though I am sure he has taken a few aspirin since. Nevertheless, the laughing in the audience and the Inspector General's crack about being upstaged by our President effectively brings into question our ability to take care of our own.

We tend to stand by and watch the whole scene as though it were some unchangeable replay of an historical event, like General Custer's last stand (and well it may be with the nihilistic and laissez faire attitudes some of use have acquired). . . .

We owe thanks to Dr. John Watson and any other patriot who earns his freedom in the act of risking his neck for us. I see that whole bunch as obviously good men working for the benefit of the rest of us all including the patients. I am glad John was not seriously hurt, and I am truly sorry I did not run up to get him out of the hole in the stage. That might have been an emergency, and I was just dozing in the audience or maybe I just didn't believe that such a thing could really happen. But those excuses just don't much hold up, do they?

Trying to be more responsible,
*Jack Tidwell, M.D.*
*Stone Mountain, Georgia*

P.S. What do you suppose should be the modus correctum on that hotel stage manager? Should we turn him over to the government, sue him, or quietly request that he attend a class on stage making and move on?

# A Board — For What Purpose??

When one undertakes any new venture, embarks on a different course of action, perhaps it is best to stop and ask a few questions. Is the direction traveled in the past the proper one? Is there a new way, a more exciting way, a more uncertain way, and yet a more interesting way to arrive at the same end? Or, the question may arise, do we even want to travel this road? Those questions, and many others, were asked in the course of evaluating this *Journal* and the direction in which it might best travel. One such consideration became the "Editorial Board," a list of whom you will find on the masthead of this issue. I looked at the previous group of individuals who for so long had faithfully performed this duty. They had been long in place and I judged, looking at my own self, perhaps found themselves weary of the task. It seemed best to suggest to these faithful individuals that they be retired after, for many of them, years of faithful service. The suggestion was received by each with universal acclaim! I found that a bit thoughtful — a bit disarming — wondering if indeed the same enthusiastic response would be forthcoming from those persons requested to become the new Editorial Board. And so the task of assembling this new group of people began.

The request to these several persons was met with universal acceptance bordering on enthusiasm. Not a single one became a "second choice." Of necessity, they represent individuals to some degree familiar to your editor. They are scattered widely around the State. They represent a diversity of medical disciplines. You need to know them.

*Carson B. Burgstiner, M.D.*, practices obstetrics and gynecology in Savannah. He is a past president of the Medical Association of Georgia and continues active in organized medicine as a delegate from Georgia to the American Medical Association.

*M. Julian Duttera, Jr., M.D.*, is engaged in the practice of medical oncology in LaGrange. He is young, enthusiastic, and had been a valuable and active member of the Georgia Division of the American Cancer Society.

*Luella M. Klein, M.D.*, is President and Chairman of the Department of Gynecology and Obstetrics at the Emory University School of Medicine. She served last year as the first female president of the American College of Obstetrics and Gynecology.

*Arlie Mansberger, M.D.*, is Chairman of the Department of Surgery at the Medical College of Georgia. He is an articulate, scholarly surgeon (a rare and precious combination) who has enjoyed the esteem of his surgical colleagues by being elected to prestigious positions on many occasions, most recently serving as the President of the Southern Surgical Society.

*W. Douglas Skelton, M.D.*, is Dean of the Mercer University School of Medicine in Macon. He represents our youngest school of medicine in the State, for many years has been active in furthering the cause of medicine in both the political and academic arena. Until recently, he was Commissioner of the Georgia Department of Human Resources.

*Louis W. Sullivan, M.D.*, is President of the School of Medicine at Morehouse University. He is a graduate of Morehouse University and Boston University School of Medicine, receiving his training in internal medicine and hematology. In the midst of a busy and time consuming academic environment, he has graciously consented to be of assistance to this *Journal*.

*William C. Waters III, M.D.*, is engaged in the practice of internal medicine and nephrology in Atlanta. Bill Waters came out of an academic environment at Emory University School of Medicine to enjoy a prestigious position in the private practice of internal medicine in Atlanta.

*Robert E. Wells, M.D.*, is an orthopedic surgeon in Atlanta. He has for some years been actively engaged in the affairs of the MAG, always willing to assist in any way he is called upon. He is the past president of the American Academy of Orthopedics and reputedly one of the few, if not the only private practitioner, to occupy this prestigious position.

*Fremont P. Wirth, M.D.*, practices neurosurgery in Savannah. He enjoys the esteem of his neurosurgical peers and for some years now has been active in the affairs of the American College of Surgeons, now serving as a Governor to that organization.

And there you have it. They are men and women from larger and smaller towns, from private practice and academia. They represent all of us. They have been asked to contribute to this *Journal* by looking at it on a monthly basis, critically viewing it as to content and organization, honestly and without fear of broaching polite social relationships to comment upon their observations. This effort on their part will make this a better *Journal*, hopefully a more widely read *Journal*. They are busy people with other things to do. They have been willing to help all of us in this endeavor. We are indebted to them.

Charles R. Underwood, M.D.
Interim Editor

# Opportunity From Times of Change

*Maureen Vandiver (Mrs. Roy W.)*
*President-elect, A-MAG*

***"Auxiliaries are making a difference through Health Fairs, Blood Drives, Anti-Smoking and Tobacco Programs, Postponing Teenage Sexual Involvement Projects, Child Abuse education, lobbying for seatbelt legislation, and tort reform — to name just a few."***

It has been a privilege and a pleasure for me to travel with our A-MAG State President, Barbara Tippins, this year. We have traveled into almost every corner of our beautiful state. It has been a unique experience which has allowed us to share problems, laugh at our mistakes, and joy in the accomplishments of auxiliaries all over the state.

Before becoming president-elect, I was hearing rumblings from members in different areas of the state. The same statements were being made over and over again. "We can't get members to attend meetings. We can't get members to take offices or chairmanships. The same few people are doing all the work each year." Are these symptoms of a weak and dying organization? I doubt that these are symptomatic of our organization alone. We have many members returning to the work force and going back to school. In the large metropolitan areas as well as small communities we must compete for members' time with many other viable volunteer groups. We should use these changes to our benefit. We must use these members wisely and hopefully their education, knowledge, and volunteer experiences can enhance our own organization. However, in our visits across the state, I have seen that the pulse and heartbeat of the medical auxiliary is strong. We continue to be a vital and integral force in our communities. Auxiliaries are making a difference through Health Fairs, Blood Drives, Anti-Smoking and Tobacco Programs, Postponing Teenage Sexual Involvement Projects, Child Abuse education, lobbying for seatbelt legislation and, of course, tort reform — to name only a few. The list is long and impressive. Auxiliaries, both large and small, are making an impact. Working together we can overcome our mutual problems by taking a positive approach toward their solutions.

It is significant to note the number of new and younger members who are joining and becoming active members. This is a necessary ingredient for both the Medical Society and its Auxiliary in order to bring ideas, creativity, and revitalization to our organization. Medicine is changing. We must keep up with these changes (like it

or not). It is the responsibility of the medical societies and the auxiliaries to EDUCATE ITS MEMBERS AND THE COMMUNITY about the changing trends in medicine and their meaning for the future. According to Pat Durham, President of AMA Auxiliary, "This year is the time to act and meet the challenges of change."

It is also the responsibility of the Medical Societies and their Auxiliaries to MOTIVATE their members to action. This is indeed a most difficult task. With innovative programming and projects and enthusiastic leadership we can continue to make our members want to be involved, and for those who are not members, to want to join. IT IS TIME TO ACT RATHER THAN REACT. We must work together to life the veil of apathy that has fallen over us, created by increasing malpractice insurance rates and the resulting stress, negative press, and changes in medicine that we may or may not agree with. From within an organization you have a voice that can effect change — from without you are but a whisper barely heard.

In the legislative area, we must also make our voices heard. Our state and federal representatives need to hear from both physicians and their spouses "personally" on issues that concern medicine. One of their chief complaints is that they do not hear directly from the physicians or spouses. Therefore, they wonder if we really care or are always willing to let someone else speak for us.

We must be a living, caring force — fighting for our causes with enthusiasm and becoming involved. We must commit more of our time and energies to bettering the quality of life in our communities. We must continue to show our friends, neighbors, and fellow citizens that we do care. Together, physicians and spouses can and are working wonders. We must also nourish our membership through education, motivation, and support systems. In our visits to auxiliaries across the state, it is clear that we are reaching these goals. The Medical Society and the Medical Auxiliary can benefit from these times of change and find new opportunities for growth and development.

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# Now the evidence looks better than ever

## Significantly reduced risk of endometrial hyperplasia

Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month.[1-4] The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

## Effect on lipids—an important feature

PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.[5]

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PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

## The most widely used, most extensively studied estrogen worldwide.

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(Conjugated Estrogens Tablets)

**Most trusted for more reasons**

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

# For moderate-to-severe vasomotor symptoms

# PREMARIN®
## (Conjugated Estrogens Tablets)

0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

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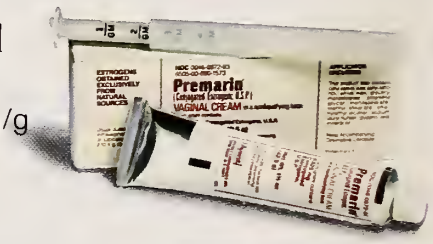
# For atrophic vaginitis

# PREMARIN®
## (Conjugated Estrogens)

Vaginal Cream

0.625mg/g




BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

**PREMARIN® Brand of conjugated estrogens tablets, USP**
**PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base**

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA.

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.
2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.
The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

**DESCRIPTION:** PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

**INDICATIONS AND USAGE:** PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

**Concomitant Progestin Use:** The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

**CONTRAINDICATIONS:** Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

**WARNINGS:** Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

**PRECAUTIONS:** Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.
b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.
c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.
d. Impaired glucose tolerance.
e. Decreased pregnanediol excretion.
f. Reduced response to metyrapone test.
g. Reduced serum folate concentration.
h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

**ADVERSE REACTIONS:** The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

**ACUTE OVERDOSAGE:** May cause nausea, and withdrawal bleeding may occur in females.

**DOSAGE AND ADMINISTRATION:**

**PREMARIN® Brand of conjugated estrogens tablets, USP**

1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.
2. *Given cyclically:* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis —0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

**PREMARIN® Brand of conjugated estrogens Vaginal Cream**

*Given cyclically for short-term use only.* For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

**References:**

**1.** Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605 **2.** Paterson MEL, Wade-Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824. **3.** Magos AL, Brincat M, Studd JWW, et al: Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985; 67: 496-499. **4.** Whitehead MI, Lane G, Siddle N, et al: Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women. *Semin Reprod Endocrinol* 1983;1:1;41-52. **5.** Barnes RB, Roy S, Lobo RA: Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219.

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## MARCH

7 — *Atlanta:* **Communicating ith the Speech, Language, or earing Impaired Adult.** Category credit. Contact Office of CME, mory Univ. Sch. of Med., 1440 ifton Rd., Atlanta 30322. PH:404/ 27-5695.

9-April 1 — *Atlanta:* **Gruentzig's dvanced Demonstrations in ercutaneous Transluminal ngioplasty, XVII.** Category 1 edit. Contact Office of CME, mory Univ. Sch. of Med., 1440 ifton Rd., Atlanta 30322. PH:404/ 27-5695.

## APRIL

— *Atlanta:* **Current Concepts in e Management of Venous seases.** Category 1 credit. ontact Dir. of Educational Serv., . Joseph's Hosp., 5665 Peachtree unwoody Rd., Atlanta 30342. H:404/851-7025.

4 *Atlanta:* **Biofeedback pplications for Patients with usculoskeletal and euromuscular Disorders.** ategory 1 credit. Contact Office of ME, Emory Univ. Sch. of Med., 40 Clifton Rd., Atlanta 30322. H:404/727-5695.

4 — *Augusta:* **Georgia Baptist edical/Dental Fellowship.** ontact Dr. Bobby Brooks, 4285 emorial Drive, Decatur 30032. H:404/294-7687.

5 — *Augusta:* **Ga. Chapter, merican College of Surgeons nnual Meeting.** Category 1 credit. ontact Charles Howell, MD, ediatric Surgery Section, MCG, ugusta 30912. PH:404/828-3941.

12 — *Atlanta:* **American College Preventive Medicine and ssociation of Teachers of reventive Medicine Joint eeting.** Category 1 credit. Contact azel Keimowitz, ACPM, 1015 15th ., NW, Ste. 403, Washington, DC 005. PH:202/789-0003.

3-17 — *Atlanta:* **Modern Methods Diagnosing and Treating iabetes Mellitus and Its Complications.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

22-25 — *Hilton Head, SC:* **Update on Surgery of the Hand and Wrist.** Category 1 credit. Sponsored by Am. Socy. for Surgery of the Hand. Contact Grady S. Clinkscales, Jr., MD, 1938 Peachtree Rd., Ste. 603, Atlanta 30309. PH:404/352-3522.

23-24 — *Atlanta:* **Maximizing Rehabilitation in Chronic Renal Disease.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

23-24 — *Atlanta:* **Rehabilitation in Organ Transplantation and Dialysis.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

23-24 — *Atlanta:* **Pharmacology For the Anesthesiologist.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

23-26 — *Atlanta:* **MAG House of Delegates.** Contact MAG, 938 Peachtree St., Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

25-26 — *Atlanta:* **The Cardiac Patient.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

27 — *Atlanta:* **Perspectives of Asthma in Late Childhood and Adolescence.** Category 1 credit. Contact the American Lung Association of Atlanta, 723 Piedmont Ave., Atlanta 30365. PH:404/872-9653.

27-May 2 — *Augusta:* **22nd Annual Family Practice Symposium.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

## MAY

3-7 — *Sea Island:* **Georgia Society of Ophthalmology Annual Meeting.** Category 1 credit. Contact Ray Williams, Exec. Dir., GSO, 938 Peachtree St., Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

7-9 — *Atlanta:* **Human Papillomaviral Infection and Lower Genital Tract Neoplasia: An Advanced Course for Pathologists and Clinicians.** Category 1 credit. Contact Mary Claire Jones, Dir. of Educational Services, St. Joseph's Hospital of Atlanta, 1100 Johnson Ferry Rd., Ste. 510, Atlanta 30342. PH:404/ 851-7025.

9-10 — *Augusta:* **Postgraduate Pathology Symposium.** Category 1 and AAFP prescribed credit. Contact William C. Allsbrook, Jr., MD, Dept. of Path., MCG, Augusta 30912. PH:404/828-3967.

17-19 — *Atlanta:* **American Society of Clinical Oncology Annual Meeting.** Category 1 credit. Contact Alfred Van Horn, ASCO, 435 N. Michigan, Chicago, IL 60611. PH:312/644-0828.

27-29 — *Atlanta:* **Advances in the Pathophysiology, Diagnosis, and Treatment of Cardiovascular Diseases.** Category 1 credit. Contact Dept. of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

28-29 — *Callaway Gardens:* **15th Annual Perinatal Medicine Conference.** Category 1 credit. Contact Div. of Perinatology, The Medical Ctr., P. O. Box 951, Columbus 31994. PH:404/571-1000.

## JUNE

8-10 — *McCormick, SC:* **Seizure Disorders in Children.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

15-18 — *Kiawah Island, SC:* **18th Annual Internal Medicine Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

# WE ACHIEVE — COUNTY ACTIVITIES

> ***"The county auxiliaries were challenged to take more visible roles in their community services, to go to the youth of the community and inform them of the rewards of good health habits and preventive health care. . . ."***

AT THE BEGINNING of the new auxiliary year, the county auxiliaries were challenged to take more *visible* roles in their community services, to go to the youth of the community and inform them of the rewards of good health habits and preventive health care, to warn them of the hazards of the use and abuse of alcohol, drugs, and tobacco. They were challenged to educate young people to the fact that they have a choice in what happens in their lives and to help them develop character skills and ideals to make the right choices, to develop assertiveness without being aggressive, and to teach them to modify their behavior to become the best individuals they can be.

Programs for older Americans, involvement in legislative activities, health education, and self-help examinations were suggested. The key words for success were *Involvement, Dedication, Commitment*. The means to the desired end was working together as a team with the medical societies, other county auxiliaries, in coalition with other health-related organizations and with the state and national auxiliaries.

The counties responded to the challenges in the ways that best fitted the needs of their local communities and the auxiliaries. These activities, as diversified as the individuals who make up the auxiliaries, were all worthwhile and timely.

*Bibb County Medical Auxiliary President, Mrs. Sarah Freant,* wrote the following account of their activities: "The Auxiliary to the Bibb County Medical Society has been involved in several interesting projects. An exciting one was our Silent Auction and Dinner-Dance held on November 13, 1986. Over $5000 was raised at this auction for AMA-ERF. The holiday sharing card is a new AMA-ERF fund raising project for the auxiliary. Mrs. Leo Erbele (Jo), a noted artist and auxilian, designed and painted the card.

"On October 9, 1986, a Mini Health Clinic was held at the Bibb County Sheriff's Department. Auxiliary volunteers assisted with paperwork, weights, blood pressures, collecting specimens, and as attendants during physical exams. This is the fourth year for this well received community service project.

"Postponing Teenage Sexual Involvement is one of our health projects. The Auxiliary is represented on a task force set up by the Bibb County Health Department to study this problem."

*Mrs. Anne Staley, President of the Cobb County Auxiliary* detailed their involvement thusly: "Since the past several years have shown the need for creating awareness, interest, and more active participation in the legislative process, the Cobb County Auxiliary felt that more emphasis should be placed on legislation. We therefore undertook a series of activities directing attention toward this increasingly important aspect of our lives. The legislative committee's first project this past July was a phone call to each member, giving the date of the primary election (August 12), information on voter registration (if needed) and the tentative date of the fall Legislative Social. In July, September, and October, a series of four voter-registration drives were conducted. On September 28, a Social for the Cobb County candidates to the Georgia General Assembly was attended by about 100 people, including 18 candidates and 8 of their spouses. The primary objective of the Social was to provide an opportunity for members and their spouses to meet the candidates informally, get to know them personally, and have an opportunity to exchange views on health-related issues.

"The Adolescent Urine Drug Screening Program, which the Cobb County Medical Society originated last year, is actively promoted by the auxiliary. The auxiliary's Publicity Committee makes the arrangements for the Public Service Announcements that are then aired on local radio stations. The auxiliary also assists in the distribution of brochures which describe this program.

***"The Adolescent Urine Drug Screening Program, which the Cobb County Medical Society originated last year, is actively promoted by the auxiliary."***

"The annual auction was held in November at the Marietta Country Club. The $2,589 raised will be shared by Calvary Children's Home, the Impaired Physicians Program, and Our Lady of Perpetual Help Home. The Auxiliary is also involved with raising money for the William R. Dancy Student Loan Fund and AMA-ERF.

"The A-MAG puppet show, 'It's O.K. to Tell,' continues to be presented in the schools. Doctor's Day in Cobb County is multi-faceted, with many activities taking place throughout the month. On March 11, 1987, a program on osteoporosis was presented at Kennesaw College. This seminar is the second in a series on 'Health Issues for Women' that the Auxiliary, in conjunction with Kennesaw College, presents to the public.

"Each year the Auxiliary awards three $1000 scholarships to students who wish to pursue a career in the allied health fields. The funds for these scholarships and our health projects come from the Kennestone Hospital Gift Shop, which is owned and operated by the Auxiliary."

*THE HOLIDAY SHARING CARD was a new AMA-ERF fund raising project for the Bibb County Medical Auxiliary. Mrs. Leo Erbele (Jo), a noted artist and auxilian, designed and painted the card. Pictured to her right is Mrs. Lawrence Freant (Sarah), Bibb County President and State Treasurer, A-MAG.*

*A HEALTH FAIR IN LAURENS COUNTY was sponsored by the Auxiliary and Medical Society of that county. Approximately 1,000 people browsed the Dublin Mall filled with health services and specialities attended by Dublin physicians, spouses, and other health professionals. Here, audiologist Richard Wright examines the ears of Kay Heard, President of the Laurens County Medical Auxiliary.*

Patterned after a national pilot program, *the Laurens County Auxiliary, conducted a Health Fair, "Medicine In Action." Mrs. Kay Heard, President,* depicted the event for this issue of the *Journal:* "The Laurens County Medical Auxiliary, along with co-sponsors Laurens County Medical Society and Fairview Park Hospital, hosted the Health Fair, 'Medicine In Action,' on Saturday, September 27, at the Dublin Mall.

"Approximately 1,000 people browsed the mall filled with health services and specialties manned with Dublin physicians, spouses, and other health professionals. Among the free services and demonstrations performed were: orthopedic implants; endoscopy, detection of breast, colon, and rectal cancer; explanation of kidney stone crushing with sound waves (lithotripsy); and viewing lithotriptor. Screening health services were eye and ear exams, a booth on skin problems and diseases, blood pressure checks, blood sugar testing, lung function studies, and EKG's. Drug and alcohol abuse information was made available by the Dublin Police Department and Brookwood Parkside Lodge.

"Many local service organizations were represented including La Leche League, American Cancer Society, American Red Cross and Three Rivers Health Services. The Organ Procurement Program from the Medical College of Georgia was also represented."

*THE WARE COUNTY AUXILIARY hosted a gourmet luncheon to raise money for a nursing scholarship. This year the theme was French, and auxilians donned French chef's hats and white aprons and served French dishes to over 150 people.*

Occasionally, some Auxiliary activities become traditions. Such is the case of the *Ware County Medical Auxiliary's "Gourmet Tasting Luncheon."* The proceeds from this go toward a nursing scholarship. *Mrs. Rose Lopez, President,* documented this annual event: "The month of May is very special to us, the members of the Auxiliary to Ware County Medical Society, because on one beautiful day of that month, when the azaleas and dogwoods are displaying their gorgeous blossoms, we sponsor our annual gourmet tasting luncheon.

"This luncheon means good food to many and they look forward to this day when they can sample delicious dishes prepared by the members of the medical auxiliary. It involves a lot of hard work and preparation, but most of all, it requires the one hundred percent cooperation of its members. This is our only fund raising project for the whole year, and it is for a good and most commendable cause. The proceeds from this luncheon support the Nurses Loan Fund, which was started 5 years ago at Waycross Junior College. Through the years, we have sponsored a number of deserving nursing students who are now practicing in various hospitals. They repay us after graduation or after they start working. This year we raised $8000 which was donated to the college."

*The Auxiliary to the Georgia Medical Society, under the leadership of Mrs. Vivian Delnostra, took on Tort Reform and Legislative Activities.* They learned nurturing and parenting from Adelle Burnsed-Gefon who wrote, "Raising Your Child's Self Esteem." GEMS (Good Emergency Mother Substitute) and Postponing Teenage Sexual Involvement "You Can Say No" continued to be vital projects.

*The Ogeechee River Medical Auxiliary, guided by Mrs. Joanne Glenn, President,* voted a dues increase to enable more community service participation, structured new By-Laws, and continued efforts on child abuse prevention.

*Mrs. Brenna Brand, President of the Auxiliary to the Richmond County Medical Society,* met and reported Auxiliary Activities to the Medical Society meeting, and The Society's President brought greetings and society information to the Auxiliary at the first meeting of the year — a nice cooperative effort. The "No Tobacco Use" slide presentation, produced by D.O.C. and the Child Abuse Prevention puppet show, were implemented in the elementary schools by the auxiliary again this year. Participation in legislative activities was spurred on by the "Low-Down on Liability" they heard from the State Legislative Chairman, Mrs. Jan Collins. The Malpractice Support Group plans, prepares, and delivers meals to physicians' families when they are in court. In addition, they make arrangements for taking care of the children while court is in session.

*The Floyd-Polk-Chattooga Medical Auxiliary, led by Mrs. Anita Smith,* dealt with legislative activities. One member is a County Commissioner, one is on the School Board, and others are involved in the political process. They also worked with G.A.T.E. and addressed such varied subjects as the "Victim Witness Assistance Program" and "Open Heart Surgery in Rome." They have a Malpractice Support Group to help colleagues involved in liability suits.

*Sumter County Auxiliary, directed by Mrs. Denise Campbell,* had an active fund raiser with the sale of the Sally Foster Gift Wrap. One member sold over two thousand dollars worth

herself, and she states the paper just sells itself. The proceeds from the sale finances community service projects. Tort Reform and Malpractice Support were other interests of the Auxiliary.

Members from the *Thomas County Auxiliary, guided by Mrs. Mary Malone, President,* have developed a pilot "non-tobacco use puppet show" for elementary grades, which utilizes the puppets used in the Child Abuse Prevention program. The puppets were handmade and so appealing to the children that the auxiliary felt they should serve more than one purpose.

***"Programs for older Americans, involvement in legislative activities, health education, and self-help examinations were suggested."***

*Mrs. Grace Walden, President, leads the DeKalb Medical Auxiliary.* Proceeds from the sale of their own version of "I Love My Doctor" T-shirts were used to purchase the Postponing Teenage Sexual Involvement Kits used in the "You Can Say No" programs taken into the schools by the auxilians. The Holiday Sharing Card, a big fund raiser, provided the means to purchasing eyeglasses for underprivileged children. Proceeds from the sales of the Low Fat Cook Book were used to purchase a Dinemap Vital Sign Monitor for the Cardiology Department at the DeKalb General Hospital, given in memory of DeKalb physician, Dr. Stan Aldridge. State President, Barbara Tippins, and the State President-Elect, Maureen Vandiver, have the DeKalb Auxiliary as home base and this year has kept auxilians busy hosting the Post Convention Board Meeting in Callaway, the Winter Executive Board Meeting in Atlanta, and the Annual Convention at the Hyatt Ravinia in Atlanta.

*AUXILIARY PRESIDENT, Barbara Tippins (center), Auxiliary President-Elect, Maureen Vandiver (left), and DeKalb County President, Grace Walden, have been an effective team this year. A-MAG's leadership used the DeKalb Auxiliary as home base and has kept auxilians there busy hosting the Post Convention Board Meeting, the Winter Executive Board Meeting in Atlanta, and the Annual Convention at the Hyatt Ravinia in Atlanta.*

These extracurricular activities did not deter members from participating in the annual AMA-ERF Buffet, Wine Tasting dinner, the Annual Blood Pressure Screening for Doctor's Day, and the joint Medical Society/Auxiliary project, the "Adolescent Urine Screen Analysis for Drugs" program.

*The Wayne County Auxiliary led for a second consecutive year by Mrs. Daré Ramsey, President,* has achieved 100% membership. The auxilary worked in coalition with the Woman's Club on Tort Reform to relieve the Liability Crisis, and they worked with the Red Cross to aid families whose homes were lost due to fires. The social events and luncheon get-togethers unite their medical community.

*Baldwin County Auxiliary has as its President for a second consecutive year, Mrs. Ann Craig.* When approached for a second term, Ann stated she would take it with the understanding that she would have the full cooperation of the members, and she did. Reaching and activating former members, working diligently to make items for raffles and auctions for AMA-ERF, and educating young people on "Postponing Teenage Sexual Involvement," "You Can Say No" were goals set and achieved by the Auxiliary.

*Mrs. Sandra Blackwell leads the Whitfield-Murray Medical Auxiliary.* Hilly, winding roads in the county led them to seek seat belts for their school buses. They continue to work on means to achieve this for all buses. Postponing Teenage Sexual Involvement, "You Can Say No," is another project of special interest to this group as the State Chairman, Mrs. Nancy Harrison, is a member of their auxiliary. Giving impetus to this project is the county's high percentage of teenage pregnancies. Continued productions of the "It's O.K. to Tell" Child Abuse Prevention Puppet Show is another method of youth education for these auxilians.

***"The counties responded to the challenges in the ways that best fitted the needs of their local communities and the auxiliaries."***

*The Crawford W. Long Medical Auxiliary* working with the medical society has for several years sponsored a night at the symphony for the public and furnished refreshments after the concert. *Mrs. Eleanor Newland, President,* believes this to be a

great public relations project. Donations to the William R. Dancy Student Loan Fund, through sales from the book, *The Medical Profession in Georgia from 1733-1983,* by Evelyn Ward Gay, and contributions to AMA-ERF were priority projects this year.

***"Auxiliaries all over Georgia met the challenges as they discovered they have a voice in the community, in the political arenas, and in education."***

*Mrs. Ann Marie Domm, President of the South Georgia Auxiliary,* worked diligently to reorganize the auxiliary, setting up new By-Laws, producing the Yearbook, Doctors' Day activities, and a nursing scholarship for a student nurse at Valdosta College. Physicians' spouses from Moody Air Force Base were invited and joined in the auxiliary activities.

*The Medical Association of Atlanta Auxiliary* chose to place emphasis on membership. *Mrs. Cheri Dennis, President,* sought to Renew, Recruit, Refresh, and Reach all medical spouses. Some of the methods she used were printed invitations to all meetings, a Victor Costa fashion show, a trip to the Betty Talmadge House, and a trip to antique shops in Bremen. The auxiliary distributed 250 AMA Auxiliary Posters on "No Smoking," and participated in the "You Can Say No" Postponing Teenage Sexual Involvement Media Kick Off Day held at the Academy of Medicine. The Auxiliary continued to present the "Drugs Are A Drag" puppet show and the "It's OK To Tell" child abuse puppet show. A Doctor's Day special event was held.

*The Tift County Auxiliary under the direction of Mrs. Sandy King,* gave the "You Can Say No" Postponing Teenage Sexual Involvement Program to 10th grades, collected toys for underprivileged children and prepared and delivered Christmas dinners for eighteen underprivileged families. Tort Reform, legislative activities, and Doctor's Day activities rounded out the year.

*The Newton-Rockdale Auxiliary led by Mrs. Carol Fountain, President,* were very interested in the Liability Crisis and Tort Reform. Their joint meeting with the medical society in January featured Rusty Kidd relaying the latest information on legislative issues. One member chose to remain involved in local politics by successfully running for a second term on the school board.

Teaching elementary anatomy and physiology to fifth grade students has been a priority project of the *Dougherty County Auxiliary.* This year, *led by Mrs. Nan B. Carter, President,* the Auxiliary decided to extend their youth education program to fighting drug abuse. After an extensive 11-week drug education course for themselves, the auxilians took their fight on drug abuse into the schools. Young people must be made to understand the devastating effect drugs have on their lives and early education is one of the keys to ending drug abuse.

***"Muscogee County Auxiliary continues its work with the Health Improvement Program (HIP), a cardiovascular education program to help young people understand their cardiovascular system. . . ."***

Legislative activities and Tort Reform were other priorities of the auxiliary.

*Muscogee County Auxiliary, directed by Mrs. Ginny Connelly, President,* continues its work with H.I.P. (Health Improvement Program), a cardiovascular education program to help young people understand their cardiovascular system and the roles smoking, diet, exercise, and stress play in keeping this system in perfect running condition. The program has been taken into the Muscogee County Schools, emphasis first being placed in 4th, 5th, and 6th grades, but efforts are being made to incorporate it into all grade levels. Drug Abuse Prevention, legislative activities, and combined meetings with the Muscogee Medical Society kept these auxilians busy.

Co-hostessing the Summer Executive Board Meeting at St. Simons Island was just one of the projects *carried out by the Glynn County Auxiliary, headed by Mrs. Diane Laws, President.* They educated themselves on the Medical Liability Crisis and proposed Legislative Reforms.

As one of its goals is "to foster friendships among its members," *the Walker-Catoosa-Dade Medical Auxiliary, led by Mrs. Peggy Marynski, President,* met each month in members' homes. The "You Can Say No" Postponing Teenage Sexual Involvement Program was one of the major concerns, as well as their own Acie Townsend Student Scholarship Fund. This scholarship is named for the late wife of Dr. Egbert Merridy Townsend and is given to a student entering one of the health career fields. A booklet, "Say No To Drugs But Yes To Life," a positive approach to worthwhile living, listing agencies in Georgia and Tennessee where help can be found, is an original proposal of this auxiliary.

Auxiliaries all over Georgia met the challenges as they discovered they have a voice in the community, in the political arenas, and in education. They used this voice for promoting a better quality of health care and life for all as "Together We Achieved."

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*You can never plan the future by the past.*
EDMUND BURKE

# MALPRACTICE SUITS: THEIR EFFECT ON DOCTORS, PATIENTS, AND FAMILIES

SARA C. CHARLES, M.D.

When a doctor is served with a complaint alleging medical malpractice, it is often the beginning of a long, disruptive, and painful life experience. The events that led to the litigation — a fatal outcome, and unanticipated or uncommon complication, a tragic result, a misjudgment — are often already the source of emotional pain and concern not only for the doctor but also for the patient and the patient's family. In most instances, the doctor did his or her best and sometimes took great risks to help the patient. To then be sued for malpractice and accused of negligence, of failure to meet the ordinary standards of care, and even of "willingly and wantonly" setting out to harm the patient, is an experience doctors frequently describe as "devastating."

Most doctors work with the belief that if they continually develop their competence and have good relationships with their patients, they will not be sued. An increasing number who have subscribed to this approach still find themselves the subject of legal accusations. This results in feelings of powerlessness, misunderstanding, and, in many instances, hopelessness.

There is no way to completely avoid the feelings and reactions that a malpractice suit generates. Feelings of anger and emotional disequilibrium, often accompanied by some somatic symptoms, are normal, human responses to a stressful life event. It means that the work of medicine is intensely interpersonal and worthy of emotional investment. Not to respond in some way is far more worrisome.

***"There is no way to completely avoid the feelings and reactions that a malpractice suit generates. Feelings of anger and emotional disequilibrium, often accompanied by somatic symptoms, are normal, human responses to a stressful life event. . . Not to respond in some way is far more worrisome."***

Litigation is generally experienced as an assault on one's sense of integrity. As a group, doctors tend to possess common personality features which render them vulnerable to such an attack. Their obsessive-compulsive personality traits stimulate them to be careful, conscientious, and prepared to consider alternative diagnostic possibilities or explore other treatment options. Doctors also tend to be self-demanding and self-critical, and they measure their peers against the same standards. That is why they are careful about their referral sources and consultants and why there will always be doctors who feel an obligation arising out of the best of motives to criticize, and often to testify against, the performance of some other physician.

This trait was well illustrated in one of our studies which compared sued and non-sued doctors. Only 21% of sued doctors thought that patients were justified in bringing their suit for malpractice. Sixty-nine percent of non-sued doctors thought they were justified. It appears that doctors feel quite free and perhaps even righteous in their tendency to evaluate the performance of their peers. When legally accused of carelessness and negligence, however, they are more often than not grievously offended and, perhaps, less inclined to criticism of their peers.

When a doctor is sued for malpractice, these same obsessive-compulsive personality traits stimulate

Dr. Charles is Associate Professor of Clinical Psychiatry, University of Illinois at Chicago. She was a featured speaker at MAG's Leadership Conference last month and has herself experienced being sued for malpractice.

self-doubt, self-scrutiny, feelings of guilt and shame, and sometimes even self-condemnation. The outcome of their patient's treatment may already be a source of anxiety and discomfort. When formal litigation is initiated, with accusations that are often fraught with distortions, the doctor may identify unconsciously — even though he may be confident of his competence and sense of responsibility — with the public view of the "bad doctor." This results in the feeling of guilty-until-proven-otherwise, despite reassurances to the contrary by their legal counsel.

### How Doctors React To Being Sued

When a summons alleging negligence is served, the doctor's initial response is disbelief and shock. "How could this happen? . . . Just give me a chance to explain myself." The insurer attempts to settle the doctor down and suggests an examination of the record and consultation with the defense attorney. The lawyer usually explains the intent of tort law, the legal process, the criteria used to establish negligence, and generally gives reassurance, "Getting sued happens to everyone . . . it is just part of the business . . . don't take it personally, it doesn't mean you're a bad doctor. . . ."

Most doctors are not reassured, do take it personally, and "settle down" to a variable period of emotional disruption. The suit often represents feelings of broken trust, betrayal, hurt, and misunderstanding. The complaint almost invariably alleges incompetence, charges of being "bad" at your work, and is experienced as a blow to one's sense of self and feelings of self-esteem. This upheaval in the usual state of emotional equilibrium which accompanies self-confidence and mutual trust generates feelings of intense anger and rage.

Individual doctors report different reactions to being sued. There are, however, identifiable clusters of symptoms and behaviors that are commonly reported by doctors who have been sued. In our studies, approximately 33% described symptoms similar to those experienced in a depressive disorder, such as depressed mood, appetite change, insomnia, loss of energy, loss of interest in usual activities, and, on occasion, suicidal ideation. Slightly more than 25% of physicians experienced symptoms which might be described as an adjustment reaction to a major life stress, with malpractice litigation as the psychosocial stressor, characterized by symptoms of intense anger, irritability, inner tension, frustration, fatigue, headache, and/or gastrointestinal complaints. Sixteen percent experienced the onset or exacerbation of a physical illness such as hypertension, duodenal ulcer, colitis, and coronary artery disease. A small number reacted by misusing drugs, especially alcohol.

Most reactions are usually self-limited and temporary but occasionally they persist and require medical or psychological intervention. For many doctors, their emotional response diminishes after a few weeks, only to reoccur at critical points in the legal process. For those doctors who go to trial, that phase of the litigation is often described as the most stressful, giving rise to both emotional and physical symptoms.

***"Litigation is generally experienced as an assault on one's sense of integrity."***

All these varied and intermittent reactions generate a variety of attitudinal and behavioral adaptations. As a result, many doctors change their feelings about themselves and their patients. In addition, the manner in which they do their work may be both immediately and permanently affected. They may begin to interact with their patients in a more defensive manner, eliminate or avoid high-risk situations, contemplate early retirement, and overall, derive less satisfaction from their work. This, coupled with the cloud of accusations of incompetence which may take many years to resolve, often leads to distancing behaviors which have long-term effects on motivation and commitment.

It is not only the doctor's patients who bear the burden of this climate of increased litigation. The doctor's spouse, who lives closely with the "defendant" and who shares those commonly reported sleepless nights with the accused, is also drawn into a totally different world by the litigation experience. In many instances, doctors may be so angry and so depressed and the initial reaction so overwhelming that they are literally incapable of sharing the agony they feel. Their spouses may feel rejected, excluded, and powerless to help. If there is any strain present in the marriage already, this may cause even more feelings of alienation. Litigation is a challenge to the strength of the marital bond and the long-term effect on the marriage is highly dependent on the strength of that bond and the willingness of both parties to ride out the storm together.

It is at home that the doctor can finally be himself — which during the litigation process can often be described as angry, frustrated, and irritable. The children may find themselves the object of their parent's rage, sometimes unprovoked or precipitated by minor incidents. Such developments necessarily demand the cooperation and understanding of both parents to acknowledge the problem, discuss the issues, and work to deal with the stresses engendered by the litigation.

The physician-owned insurance company in Illinois reports, as do many of its counterparts in other sections of the country, that four of every five suits closed result in no payment to the plaintiff. Almost three-fourths of doctors who go to trial successfully vindicate themselves. Such data, which document the outcome of suits filed ostensibly to deter bad medical practice, suggests that "good doctors" rather than "bad doctors" are most frequently the object of litigation. The final outcome and long-term effects of such a major life experience on an ever widening group of professionals, their families, and their patients has yet to be fully documented.

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|---|---|---|---|---|---|
| HYDROCODONE | | X | | | X |
| CODEINE | X | X | X | X | X |
| OXYCODONE | XX | XX | XX | XX | XX |

**Blank space indicates that no such activity has been reported.**

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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**Information For Patients:** VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
**Cough Reflex:** Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
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The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982. S68S


1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.


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# YOU CAN SAY NO

## TEENAGERS — DON'T BE PRESSURED INTO SEX.

BY SHERRY MARSH

On January 21, 1987, the kick-off news conference for the "You Can Say No" Campaign aimed at reducing teenage sexual involvement, was held at the Academy of Medicine in Atlanta. Featured speakers included Mrs. Joe Frank Harris, First Lady of Georgia; Dr. John D. Watson, Jr., President of MAG; Mrs. William C. Tippins, Jr., President of the Auxiliary to the MAG (A-MAG); and Dr. Marion Howard of Grady Teen Services in Atlanta. Invited guests included physicians; auxilians; legislators; state, city, and county officials; civic groups; community volunteer organizations; and news media around the state.

The MAG and A-MAG are sponsoring this campaign, directed at encouraging Georgia teenagers to postpone sexual involvement until they are more physically, financially, and emotionally equipped to handle the possible consequences. The major goals of this campaign are to increase community awareness of the problems of early teen sexual involvement and, ultimately, to reduce Georgia's high teen pregnancy and infant mortality rates.

Currently, over half of the 258,000 teenage girls in Georgia aged 15-19, and almost 5,000 of the teenage girls aged 10-14 are believed to be sexually active and thus

Ms. Marsh is Director of Communications at MAG.

at risk of becoming pregnant. And the numbers are on the increase. Although the availability of educational and medical programs *has* had some impact on teenage pregnancy in Georgia among girls 15-19 years of age, the pregnancy rate among younger teens (aged 10-14) continues to rise. Of these sexually active teenagers, one out of four never uses contraception.

***"The major goals of this campaign are to increase community awareness of the problems of early teen sexual involvement and, ultimately, to reduce Georgia's high teen pregnancy and infant mortality rates."***

This increasing sexual involvement among Georgia's teenagers has created an epidemic of teenage pregnancies in Georgia. Last year alone, there were over 26,000 teenage pregnancies in the state — 131 pregnancies for every 1000 women aged 15-19. This was higher than the national average of 88.5 pregnancies per 1000 women 15-19, ranking Georgia *fifth* highest in the nation in the number of teenage pregnancies.

The physical, emotional, and social consequences of unwanted teenage pregnancy include abortions, poor prenatal care, premature infants, and child abuse and neglect. The physical and emotional scars left by unintended pregnancy are costly and traumatic to teen mothers, teen fathers, and their infants. In fact, infants born to teen mothers tend to be high risk infants — more likely to be premature, retarded, or disabled and more likely to die during their first year of life than babies of mothers aged 20 to 29.

Teenage mothers are ten times more likely to commit suicide than are their peers. And teenage mothers most often interrupt their schooling, condemning themselves to lower levels of educational achievement. But pregnancy is not the only adverse outcome associated with early teenage sexual involvement.

Sexually active teens greatly increase their risk of contracting sexually transmitted diseases such as gonorrhea, syphilis, herpes, and AIDS. According to the Youth and AIDS Prevention Program/AIDS Health Project of the University of California, San Francisco:

— Fifty percent of all teenage girls have had sexual intercourse, with some 16 percent reporting 4 or more partners;

— Eighty-five percent of reported sexually transmitted diseases occur in persons 15 to 30 years of age; and

— Approximately 21 percent of all AIDS cases in this country fall within the 20-29 year-old range. *However,* because of the long incubation period for AIDS — up to 7 years — many of these young adults may have first been infected as teenagers.

There is a common personality trait among many teenagers who engage in early sexual activity. They are often teens who have low self-esteem and little confidence in themselves. They become sexually active perhaps to feel loved or needed, or to belong, yet they often feel worse about themselves after they have sex than they did before.

For this reason, the MAG and A-MAG have developed a campaign aimed at not only helping teens postpone sexual involvement but also encouraging them to overcome sexual and peer pressures — the first step in effectively saying "no." The Campaign will also: provide teens with accurate, factual information in order to dispel the myths, misinformation, and misconceptions they may have about sexual involvement; and educate parents of teens on the feelings that a teen faces and how they can help their teens deal with these feelings.

According to Mrs. William C. Tippins, Jr., President of A-MAG, this will be accomplished through a concerted effort by the MAG and the A-MAG. Since members of the medical profession and those connected with the medical profession have been traditionally respected leaders in the community, they have the power to garner public support and take a leadership role in community efforts to reduce teenage pregnancy. It will, therefore, be up to the medical community to take this issue statewide and raise public awareness.

***"Currently, over half of the 258,000 teenage girls in Georgia aged 15-19, and almost 5,000 of the teenage girls aged 10-14 are believed to be sexually active and thus at risk of becoming pregnant."***

A variety of campaign components have been developed to make the "You Can Say No" effort successful. Information kits containing news releases, fact sheets, suggested feature ideas, public service announcements, bumper stickers, buttons, and brochures have been sent to all county auxiliary and county medical society presidents to be used in obtaining media coverage and educating the public. There is also an educational series, complete with slide show and training manual, entitled, "Postponing Sexual Involvement," which the county auxiliaries are working to implement in their local school systems. The series is designed to provide young people with tools to help them bridge the gap between their physical development and their cognitive ability to handle the implications of such development.

One of the campaign objectives, according to Mrs. Tippins, is to get the "Postponing Sexual Involvement" series into every Georgia school system. At present, 60 county/city school systems have purchased the program and 53 county/city school systems have teachers who have been trained to use the program.

***"The campaign is aimed at not only helping teens postpone sexual involvement but also encouraging them to overcome sexual and peer pressures — the first step in effectively saying 'no.'"***

In order to get news of the campaign to the people, two 30-second television, and three 30-second radio public service announcements have been created and produced. These spots reinforce the message that peer pressure *can* be effectively overcome and teenagers *can* say no if they feel they are really not ready for sex. The spots also emphasize the negative impact pregnancy and child rearing have on teenagers.

The most positive aspect of the "You Can Say No" Campaign, however, it that it assures teenagers they are not alone in their desire to delay sexual involvement. When they discover that half of all teenagers are *not* sexually active, it may make their decision to say "no" easier. Teens are so often worried about "fitting in" and "being accepted," it should be comforting to them to know there are many other teenagers who have made the same decision they have made about postponing sex.

***"As community leaders, members of the medical profession have the power to garner public support and take a leadership role in community efforts to reduce teenage pregnancy."***

The "You Can Say No" Campaign is just the tip of the iceberg. It will, ultimately, be up to the media and the people of Georgia to ensure that the state's teenagers receive the proper education to enable them to make informed decisions about sexual involvement.


**There is a School in Atlanta for kids in trouble with drugs**

**434-4443**

**ACTION**

*4885 Argo Road • Smyrna, GA 30080*

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**There is a Treatment Program in Atlanta for families and kids in trouble with drugs**

**434-4443**

**ACTION**

*4885 Argo Road • Smyrna, GA 30080*

# PHYSICIANS, SCHEDULE SOME TIME FOR YOUR COUNTRY.

Many physicians would like to devote some time to their country in a local Army Reserve unit. We know that making a weekend commitment can be difficult for most physicians. So it is practical for the Army Reserve units to be flexible about time. It's worth discussing.

Incidentally, in addition to satisfying your own desire to serve your country, there are exceptional opportunities to do something totally different from a day-to-day routine. Opportunities to study new areas of medicine, meet new people in your specialty, and be a part of one of the world's most advanced medical teams.

Discuss the opportunities with our Army Medical Personnel Counselor.

# FOR SURGEONS LOOKING FOR A CHALLENGE.

Your challenge could be the Army Reserve unit near you. It's a unit that requires the services of surgeons.

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You'll also have an opportunity to participate in a number of programs in which you'll be able to exchange views and information with other surgeons from all over the country.

The Army Reserve understands the time demands on a busy physician, so you can count on us to be totally flexible in making time for you to share your specialty with your country. We'll arrange your training program to work with your practice.

To find out about the benefits of serving with a nearby Army Reserve unit, we recommend you call our Army Medical Personnel Counselor.

# PHYSICIANS, THERE ARE TWO KINDS OF FLEXIBILITY IN THE ARMY RESERVE WE THINK YOU'LL LIKE.

One, time. We know how tough it is for a busy physician to make weekend time commitments. So we offer flexible training programs that allow a physician to share some time with his or her country. We arrange a schedule to suit your requirements.

Two, the opportunity to explore other phases of medicine, to add a different kind of knowledge—the challenge of military health care. It's a flexibility which could prove to be both stimulating and rewarding, with the opportunity to participate in a variety of programs that can put you in contact with medical leaders from all over the country.

See how flexible we can be, call our Army Medical Personnel Counselor.

**ARMY RESERVE. BE ALL YOU CAN BE.**

# HERE'S ONE DOCTOR WHO WON'T PAY HIS MALPRACTICE PREMIUMS THIS YEAR.

The Army covers his premiums. Since he's an Army Physician, there are a lot of worries associated with private practice that he won't have to contend with. Like excessive paperwork, and the overhead costs incurred in running a private practice.

What he will get is a highly challenging, highly rewarding experience. The Army offers varied assignments, chances to specialize, or further your education, and to work with a team of dedicated health care professionals. Plus a generous benefits package.

If you're interested in practicing high quality health care with a minimum of administrative burdens, examine Army medicine. Talk to your local Army Medical Department Counselor for more information.

**ARMY MEDICINE. BE ALL YOU CAN BE.**

# MAJOR OPPORTUNITIES FOR HEALTH PROFESSIONALS.

**Army/Army Reserve Medicine**
**Bldg. 922, N. End**
**Fort Gillem**
**Forest Park, GA 30050**
**Call collect: (404) 362-3359 or 3377**

# ACTION

*4885 Argo Road • Smyrna, GA 30080 • (404) 434-4443*

## There is a Team in Atlanta which works with you as you work with families and kids in trouble with drugs

## 434-4443

**It's hard enough to ask for help.**
**It shouldn't be hard to get it.**

Ridgeview
The First Step

# "YES, THERE IS LIFE AFTER BREAST CANCER. AND THAT'S THE WHOLE POINT."

—Ann Jillian

A lot of women are so afraid of breast cancer they don't want to hear about it.

And that's what frightens me.

Because those women won't practice breast self-examination regularly.

Those women, particularly those over 35, won't ask their doctor about a mammogram.

Yet that's what's required for breast cancer to be detected early. When the cure rate is 90%. And when there's a good chance it won't involve the loss of a breast.

But no matter what it involves, take it from someone who's been through it all.

Life is just too wonderful to give up on. And, as I found out, you don't have to give up on any of it. Not work, not play, not even romance.

Oh, there is one thing, though.

You do have to give up being afraid to take care of yourself.

AMERICAN CANCER SOCIETY®
Get a checkup. Life is worth it.

# To show you how many hypertensives stayed on

# INDERAL® LA
(PROPRANOLOL HCl)

# after a major nationwide trial...

...we had
to find
just the
right room.

# 60,073 patients (90%) who started on INDERAL® LA stayed on INDERAL LA.[1*]

## Surprising? Not really.

**Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.**
**A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients[2] revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol—which shows how well-tolerated once-daily INDERAL LA can be.**

## Sole therapy or concomitant therapy? Fifty-nine percent of the time, INDERAL LA stood on its own.

The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were controlled merely with the addition of a diuretic to INDERAL LA.

## For the noncompliant patients in your practice, INDERAL LA may well be the answer.

Almost 20,000 of the patients in the nationwide compliance trial were identified as having been noncompliant with their previous antihypertensive therapy. Their physicians reported that 88% showed improved compliance when placed on once-daily INDERAL LA.

# Control, comfort, and compliance

ONCE-DAILY
**INDERAL® LA**
(PROPRANOLOL HCl)
LONG ACTING CAPSULES

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

# The one you know best keeps looking better

Please see next page for brief summary of prescribing information.

# The one you know best keeps looking better

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

**INDERAL® LA** brand of propranolol hydrochloride **(Long Acting Capsules)**

**DESCRIPTION.** Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

**CLINICAL PHARMACOLOGY.** INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

**INDICATIONS AND USAGE. Hypertension:** INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

**Angina Pectoris Due to Coronary Atherosclerosis:** INDERAL LA is indicated for the long-term management of patients with angina pectoris.

**Migraine:** INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

**Hypertrophic Subaortic Stenosis:** INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

**CONTRAINDICATIONS.** INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

**WARNINGS.** CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

**Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)**—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

**PRECAUTIONS.** *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

*Clinical Laboratory Tests:* Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

*Carcinogenesis, Mutagenesis, Impairment of Fertility:* Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

*Pregnancy:* Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

*Nursing Mothers:* INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

*Pediatric Use:* Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS.** Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

*Cardiovascular:* bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

*Central Nervous System:* lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

*Gastrointestinal:* nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

*Allergic:* pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

*Respiratory:* bronchospasm.

*Hematologic:* agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

*Auto-Immune:* In extremely rare instances, systemic lupus erythematosus has been reported.

*Miscellaneous:* alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

**DOSAGE AND ADMINISTRATION.** INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

**REFERENCES:**


1. INDERAL LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985;145:1321-1323.


**6412 187**

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# Changing the Professional Liability Environment Through Good Practice Policies

**Rachael Blum, J.D.**
*Director of Loss Prevention*
*MAG Mutual Insurance Company*

We are facing a society drunk with lawsuits, resulting in escalating insurance premiums, expectations of perfection, patients suing over known complications, attorneys filing suit first and researching later, and obstetricians refusing to deliver babies because risks are simply too high. In response to this serious situation, MAG Mutual Insurance Company is pleased to announce the launching of our new loss prevention program, *Good Practice* POLICIES, with the Medical Association of Georgia. Together we have developed a multifaceted approach to minimize the frequency and severity of claims and address your professional concerns. *Good Practice* POLICIES will help you protect your practice, reduce your liability risks and improve our health care climate. Our new program is designed to meet not only your needs, but the needs of your office staff and your spouses. Additionally, MAG Mutual will be awarding premium discounts to those physicians who attend and participate in the loss prevention seminars designed for them.

## Not Just Another Series of Seminars

We have expanded our Loss Prevention Department and committed more resources to the development of *Good Practice Seminars.* We have assembled a team of experts who know how to *enable* you and your staff to prevent lawsuits while at the same time assembling the kind of data you might need should you become involved in one. We are visualizing an end to the problem and creating new ways to reach the solution.

In essence, we are bringing the program directly to you, with an opportunity to earn CME credits and premium discounts. All of our loss prevention seminars will be ½ day programs, offered in many different locations around the state to provide convenience and easy access. Our program includes seminars to fine-tune you and your staff, a video-tape loan library, printed reference and follow-up materials, as well as on-call personal attention for your questions and office procedures.

*We will help you become the kind of person no one would* want *to sue!*

For new policyholders, including newly licensed physicians and physicans who have not previously attended a risk management seminar, we will be offering an introductory *Good Practice Seminar.* You'll learn about professional liability, as well as some basic medical/legal insurance terms, and some of the causes of the professional liability crisis. Our experts will explore specific actions physicians can take in the current professional liability climate.

Good Practice Seminars *will help you protect your practice, reduce your liability risks and improve our health care climate.*

Claims continue to increase in number and jury verdicts are reaching outrageous levels, particularly where deliveries and surgery are involved. Therefore, we have created special programs to focus on Obstetricians and Family Practitioners who deliver babies, and on the surgical specialties. Seminars for these groups will analyze the causes of professional liability claims in these specialties and provide guidelines in how they can be prevented.

In our studies thus far about causes of claims, we have discovered that communication—with patients, staff and other health care providers—is a critical element of prevention. So we'll be coaching you in fine-tuning your listening and communication skills.

We will look at patient expectations, and communicating the bad result. We will give you on-site exercises and some simple, useful tools to apply in your practices. We will help you become the kind of person no one would *want* to sue!

## Services In Your Office

In addition to *Good Practice Seminars*, we are creating a Video Tape Loan Library for you and your staff. You will be able to view the video tapes and review a particular loss prevention topic right in your own office. New printed materials will enhance your reference and study, and a series of posters for your hospitals will amplify the message of the program. As the new preventive program grows, we will be coming to your city for seminar training, and also to your office to do practice consultations. We will work with you to identify special problems and will provide guidelines for improvement.

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# DATES TO REMEMBER FOR LATER THIS YEAR . . .

## MAG LEGISLATIVE SEMINAR

July 17-19
Stouffer's Pine Isle Resort
Lake Lanier

## MAG SCIENTIFIC ASSEMBLY

November 20-22
Ritz-Carlton Buckhead Hotel
Atlanta

# SAYING "NO" TO SEXUAL INVOLVEMENT:

## A SKILL TEENS CAN BE HELPED TO USE

*By Marion Howard, Ph.D.*
*Associate Professor: Department of Gynecology and Obstetrics;*
*Emory University School of Medicine*
*Clinical Director: Teen Services Program*
*Grady Memorial Hospital*

More and more young people are engaging in sexual relations. The long range consequences to themsleves are not clearly understood by many of these youth. They even less understand the possible consequences for society.

Although some young people use contraceptives to help minimize potential negative outcomes, a national Harris poll released in December, 1986, indicated that only about a third of sexually involved teens practice such birth control consistently. As a consequence, pregnancy remains one major outcome of early sexual involvement among young people. At the other end of the spectrum, infertility rates also are rising among those who began sexual intercourse early and continued to have sex over time with a variety of partners.

There are other negative outcomes for individuals and society as well. Harm can come from sexually transmitted diseases. Herpes is currently incurable. Although AIDS has not yet impacted dramaticaly on the teen population, its trajectory indicates eventually it will. Pelvic inflammatory disease and cervical cancer are increasing among those young women who have had multiple sexual partners.

Although early and continued sexual involvement is clearly a risk-taking behavior for the young, unfortunately too many young people come to the conclusion that either they should not have been having sex or should have been using contraceptives only after they fear they already have become involved in a pregnancy or have already contracted a disease.

Why do young people not handle sexual involvement better? For example, most young people know pregnancy and sexually transmitted diseases are a consequence of sexual behavior. Indeed, when over a thousand young people in Cleveland, Ohio, and Atlanta, Georgia, were asked in small groups to list reasons why youth should postpone sexual involvement, three most commonly given reasons were: (1) pregnancy, (2) too young, and (3) sexually transmitted diseases.

Thus, knowledge about harmful effects of early sexual activity, although an important aid to helping young people make decisions about whether or not to engage in sexual intercourse, may not be sufficient to help youth guide behavior. Even basic facts about how to prevent pregnancy and sexually transmitted diseases and improved access to services may not be sufficient to bring about as much of the change as desired. What both these solutions ignore are the reasons why young people become sexually involved in spite of their knowledge about the risks.

*Giving young people skills to be able to resist social and peer pressure can be the most important educational component to add to basic fact giving. Two new and exciting educational efforts, being undertaken in Georgia, show how much skill building can be accomplished.*

Most recent research on reasons for early sexual involvement among the young, including the already cited Harris Poll, show youth naming social and

peer pressures as the main reasons for teens having sex. Thus, giving young people skills to be able to resist social and peer pressures that lead them into early sexual involvement before they either want to become sexually involved or are ready to handle all the responsibility that should go along with a sexual relationship can be the most important educational component to add to basic fact giving. Two new and exciting educational efforts, being undertaken in Georgia, show how such skill building can be accomplished.

The educational series "Postponing Sexual Involvement" was developed at Grady Hospital and Emory University to help adolescents deal with social and peer pressures and is now being disseminated throughout the state. The educational series assists adolescents in looking at why they think they have to become sexually involved. It helps them think through how the short-term gains they think will make by engaging in sex could lead to long-term unanticipated consequences. It also helps them see that many of the needs they are trying to meet could be better met in other ways.

The series discusses levels of physically expressing affection and emphasizes the importance of deciding on a stopping point and being able to convey that to a boyfriend or girlfriend. The series explains relationships to young people and highlights the variety of relationships young people can have, including the fact that it is possible for people even to have an intimate relationship with one another without becoming sexually involved.

Early findings from a study of the "Postponing Sexual Involvement" Program's effect on low income youth indicated those young women who hadn't had the program were three times more likely to begin having sex in the eighth grade than those who had been given the educational series. Youth given the program attended five classroom periods of exercises and discussions on "Postponing Sexual Involvement" as well as five classroom periods of basic factual information.

*The "Postponing Sexual Involvement" Educational Series is aimed at students in middle grades. Now, however, it has a sequel which is appropriate for both middle and high school audiences: the "Making Responsible Decisions" Program.*

The "Postponing Sexual Involvement" Educational Series is aimed at students in middle grades. Now, however, it has a sequel which is appropriate for both middle and high school audiences: the "Making Responsible Decisions" Program. The "Making Responsible Decisions" Program was released by the Emory/Grady Teen Services Program in October of 1986. The program consists of a thirty-minute videotape of a play as it was performed before a high school audience and comes with a guide for leading discussions. The guide also provides instructions for putting on the play live instead of using the videotape.

The educational program, "Making Responsible Decisions" was developed to help young people sort through information, ideas, and pressures regarding teen sexual involvement. The developers chose the format of a play for the program, since it provides unique opportunities for giving information as well as for role modeling.

The focus of the play is on a young man who is experiencing pressures from society and peers to become sexually involved with his girlfriend. The dilemma this creates for both the young man and the young woman and how they resolve the conflict provide the drama for the play.

Narrators for the play provide commentary that illuminates the action in the play and helps teens understand the importance of making responsible decisions.

The responses of youth and teachers to the play were extremely positive. During the 1985 school year, over 5000 students saw the play. Two thirds of these students (3,579) turned in an evaluation of the play. When asked to rate the play as either good, fair, or not very good, the vast majority of the students (three quarters) gave the play an excellent rating. Almost all of the rest of the students called the play "good." Only a few students thought it was either fair (4%) or not very good (2%). An overwhelming 89% said they thought the play should be given at their school the following year.

Perhaps the most important question students were asked was whether or not they thought the ideas they heard in the play would be helpful to them in making decisions about having sex. Three-quarters of the students (2,670) indicated that the play would be helpful to them. An additional 14% (515 students) thought it might be helpful to them. Only a small proportion either said it would not be helpful to them (8%) or said they didn't know whether or not it would be helpful to

*The educational program, "Making Responsible Decisions" was developed to help young people sort through information, ideas, and pressures regarding teen sexual involvement.*

them (2%).

It may be that the impact of the play is best shown by individual students comments such as:

"I learned you don't have to have sex with a person to show you love them."

"Now I can understand if a girl says no to me."

"I really enjoyed your program, and I don't think it could have come at a better time for me."

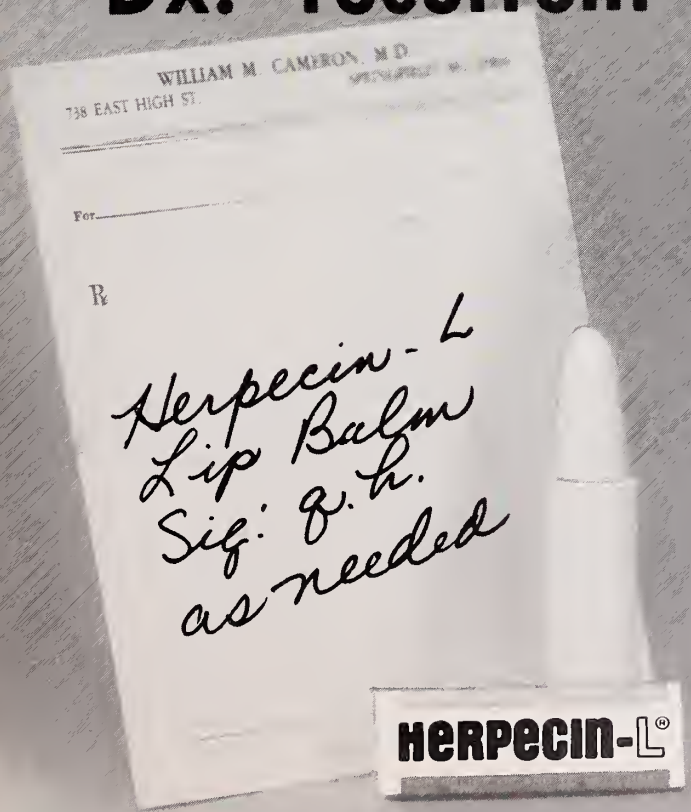
"I learned to think about the other person's feelings before making a decision."

"I learned you have the right to make up your own mind about having sex."

"I was in the same situation and I feel that this information has helped a great deal in my decision."

In January, 1986, the Medical Association of Georgia and its Auxiliary launched a state-wide campaign aimed at helping young people say no to sex. The two programs described above should be valuable resources for commmunities wishing to join in this state-wide venture. There is a special role parents can play. The "Postponing Sexual Involvement" Educational Series for Young People has a companion Series for parents which can be conducted on a group basis in one or two sessions. In addition, since so many homes now have videotape equippment, the "Making Responsible Decisions" program can be used individually at home whre parents can watch it with their teens and then discuss it. PTAs or other groups might put the videotape in a lending library so parents could have ready access to it. Both programs are available from the Teen Services Program at Grady Memorial Hospital in Atlanta, Georgia, for minimal cost. ■


# Dx: recurrent herpes labialis

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Wednesday afternoon and Thursday, it was this Medical Practice Bill which drew the delegates' closest attention at the House's final session on Friday. Their discussions reflect just how far Georgia physicians have come—or haven't come—regarding work with the state legislature.

*Comments from the audience on Dr. Dean's address suggest that in 1913, as in 1987, doctors in Georgia had a difficult time getting favorable legislation passed by the Georgia General Assembly.*

The issue at hand was the licensing of physicians. In 1913, Georgia had three medical licensing boards—the Regular, the Homeopathic, and the Eclectic—each with different standards for granting medical licenses. MAG delegates in Savannah were virtually unanimous in calling for a single composite licensing board, and for legislation that would create such a board. The question was, how could MAG help to get the Medical Practice Bill enacted by the Georgia General Assembly? Advice was given by Dr. C. T. Nolan of Marietta, one of MAG's alternate delegates to the AMA (in 1913, we had two delegates and two alternates; today we have seven each). Dr. Nolan's remarks to his colleagues resemble the exhortations which modern MAG members are likely to hear from Dr. Jim Kaufmann or Rusty Kidd. "We are in need of this new law," said Dr. Nolan, "but we will not get it unless we go to work. The osteopaths, the homeopaths, patent medicine fakers, Christian Science people, etc., you will find lining up and fighting; and you will not beat them unless you, yourself, fight. See the member of your legislature in your home county, and do not depend on some one else to do this. That is the only way to get the law through." Other delegates agreed, and the House of Delegates ended up passing a motion calling for a committee of physicians from every district in the state to go to Atlanta and lobby for passage of the Medical Practice Bill. (As we know, the bill was subsequently passed, creating our present-day Composite State Board of Medical Examiners.)

There were only a few other pieces of business voted on by the House during those 3 days in Savannah. To be sure, the election of officers was an important item on the agenda. Several resolutions were also taken up. In one vote, the MAG delegates called on the Southern Medical Association to create a section on Pediatrics. Delegates also passed resolutions in support of a free hospital for the treatment of indigent crippled children and for cooperation with the state government in defining the authority of the State Board of Health. Another item discussed would probably send shivers through our Association's legal counsel were it even

dimly-lit schools of the day. A paper by Clarence A. Rhodes, M.D., of Atlanta, "A Plea for More Interest in Pediatrics," implored general practitioners to recognize the "pediatrist" as a specialist rendering valuable patient care. Dr. Rhodes' concluding comment—"The pediatrist wants to treat only the infants and children and not the adults, so don't be afraid of his stealing the whole family when he is called in"—reminds one of the concerns about "patient-stealing" voiced today among medical specialties.

Some scientific papers were judged to be of general interest, and were scheduled for plenary sessions. At one of these, a special guest speaker, Dr. J. Ewing Mears of Philadelphia, delivered an address entitled, "The Problems of the Social Evil Considered in its Social and Medical Aspects and in its Relation to Race Betterment." The "social evil," of course, is what we would today call "sexually transmitted diseases," and Dr. Mears was talking about it in relation to its transmission by prostitutes. While his discussion may strike us today as overly delicate, Dr. Mears' proposal—that prostitutes submit to mandatory medical examination for syphilis and gonorrhea—sounds remarkably similar to proposals being advanced in 1987 by the Georgia Department of Human Resources for the mandatory testing of prostitutes for AIDS.

Titles of other papers delivered at MAG's 1913 meeting appear quaint. An Atlanta physician, for example, spoke on "Sterilization of Confirmed Criminals, Idiots and Rapists"; another delivered a paper on "Segregation Versus Sterilization of Defectives." A few papers addressed non-clinical subjects, and in these we can see that doctors' attitudes don't change. Take physicians' alleged opinion of attorneys. One paper read by J. G. Dean, M.D. of Dawson, addressed the differences between doctors and lawyers. While physicians work to reduce the instance of disease and thereby lessen the public's need for their professional services, attorneys, Dr. Dean asserted, work to *increase* the public's need for their services. "Is it not a notorious fact," he asked his audience, "that all our legislative bodies are filled with members of the legal profession, and is not their chief purpose there to add more laws to the already overcrowded statute books? What does this mean if not that the barrister is adding to the possibility of making business for himself? What a difference here between the doctor and the lawyer!"

Comments from the audience on Dr. Dean's address suggest that in 1913, as in 1987, doctors in Georgia had a difficult time getting favorable legislation passed by the Georgia General Assembly. Said one Macon physician, "If we would get together and fight the lawyer-politician, giving him the devil as he does us, we should get laws passed that would protect us as medical men and make our influence felt as it should be." Others agreed, recounting the problems which MAG was having in securing passage of a Medical Practice Bill.

While the reading of scientific papers took up most of the House agenda on

# The Medical Association of Georgia House of Delegates

# 1913

*Stephen Davis, Ph.D.*

You never know what you'll find in an old desk drawer. . . .

A while back, one of MAG's staff members was cleaning out one of our offices. In a long-unused desk, he chanced upon the accompanying "centerfold" picture. Printed on heavy photographic paper, yellow with age, and rolled into a coil, the more than 2-foot-long photo depicts the attendees of the Medical Association of Georgia's 64th Annual Session, held in Savannah at the DeSoto Hotel, April 16-18, *1913.*

*In 1913, medicine's hottest issue before the state legislature involved the establishment of a single Composite Board of Medical Examiners.*

Back then, things were different in medicine (as you may have guessed). The number of physicians in Georgia numbered not quite 3,000. MAG membership totaled 1,500 physicians, a fourth of what it is today. In 1913, medicine's hottest legislative issue before the state legislature involved the establishment of a single Composite Board of Medical Examiners, to replace the three existing boards regulating allopathic physicians ("regulars"), homeopaths, and "eclectic" physicians.

Other concerns of these physicians, pictured as they stood on the lawn in front of the old DeSoto (where the Hilton stands today), seem laughably outdated. In some respects, though, the interests of the MAG House of Delegates in 1913 are similar to those of MAG today—as we found when we rummaged through the Official Proceedings of that House, three-quarters of a century ago. . .

* * * * *

As prescribed by MAG's Bylaws, the 64th Annual Session convened at 9 o'clock on the morning of the third Wednesday in April. Dr. W. W. Pilcher of Warrenton, MAG's President, rapped the gavel and began the first general session, replete with florid addresses of welcome from the Mayor of Savannah and the President of the Georgia Medical Society. Then the assembled delegates began the main business of their meeting—not debating issues relating to health legislation or medical socioeconomics, as we do today in the MAG House—but the presentation and discussion of scientific papers. The "Committee on Scientific Work" had accepted 95 papers to be read by MAG members during the 3-day meeting—so many papers that most had to be presented in speciality sections.

There were thus Medical and Surgical Sections on the afternoon of Wednesday, April 16, and during Thursday, too. Speakers' papers, followed by general discussion from audience members, included such topics as "Chronic Interstitial Nephritis," by W. B. Hardman, M.D., of Commerce; "Appendicitis without Appendiceal Symptoms," by R. M. Harbin, M.D., of Rome; "Post Operative Hemorrhage and Surgical Shock," by W. W. Battey, Jr., M.D., of Augusta; and "Is Floating Kidney a Surgical Disease?" by William Perrin Nicholson, M.D., of Atlanta. Shorter sections on Ophthalmology/Otology/Laryngology and Pediatrics were also held, in which papers reflected the medical concerns of the times. Hugh M. Lokey reported on "The Care of the Eyes of Children Employed Indoors," and found that kids working in factories (remember—the federal Child Labor Act was not passed until 1916) had better eyesight than children attending

*Dr. Davis is MAG's Director of Education.*

*mentioned* in a House meeting today: the delegates voted that MAG's Legislative Committee should work with the Board of Trustees of the "State Sanitorium of Milledgeville" to draft a bill to allow the sterilization of the criminally insane. (Think of that as a resolution from our House, in today's litigious society!)

*We know from the Official Proceedings that Dr. Hardman, Dr. Harbin, and Dr. Phinizy Calhoun attended MAG's 64th Annual Session—all were forebears of physicians practicing medicine today in Georgia.*

But then, as always, delegates to the MAG House in 1913 were interested in conviviality and entertainment, as well as work. Accordingly, the Committee on Local Arrangements provided for an oyster roast on Thursday evening, at the Savannah yacht club. Plans for Wednesday evening might be thought of as sexist today. While the doctors' wives were taken to a fish dinner at the Casino Restaurant in nearby Thunderbolt, the doctors themselves were scheduled to enjoy each others' company in an "informal smoker" at the hotel. (We remember that the term "cocktail party" did not become in vogue until the 1920s. Moreover, it was not viewed as socially acceptable, in 1913, for women to drink at a party with men.)

Then we come to our centerfold picture. Late in the morning session on Wednesday, Dr. Ralston Lattimore of Savannah, Chairman for Local Arrangements, announced to the House, "I have here, Mr. President, a note from Mr. Foltz, who is the official photographer of the Association. He says that the weather today is ideal for a photograph, and that immediately after the close of this general session he would like to photograph the Association." It was a good idea, so after the reading of another paper, President Pilcher called on the assembled members and delegates to gather on the lawn in front of the hotel. There they met, and were photographed as you see them here.

We suspect that some of these faces will be familiar to present-day members of MAG. We know from the Official Proceedings that Dr. Hardman, Dr. Harbin, and Dr. Phinizy Calhoun attended MAG's 64th Annual Session—all were forebears of physicians practicing medicine today in Georgia. Dr. A. J. Mooney of Statesboro, a Vice-Councilor for MAG's First District, probably also stood in the DeSoto Hotel courtyard that afternoon; his grandson, A. J. Mooney, III, continues to practice in Statesboro.

Recognize any of these physicians? The Editor invites responses from our readership. And we hope you join us in appreciating these MAG members—sturdy predecessors of those who will convene next month for another MAG House of Delegates, 74 years later. ■

# THE IMPAIRED PHYSICIAN: THE ROLE OF THE SPOUSE IN RECOVERY

G. DOUGLAS TALBOTT, M.D.

*The Auxiliary plays a critical role in the identification and recovery of the impaired physician.*

THE GEORGIA Impaired Physicians Program (IPP) has just treated its 1300th physician. The accomplishment has been in large part of a result of the influence of the Auxiliary to the MAG. Since the inception of the IPP, the presidents and officers of the Auxiliary have assigned top priority to the Program. This year's officers, President Barbara Tippins and President-elect Maureen Vandiver, have continued this tradition.

The spouse participates in the four major stages of the physician's recovery from alcohol and/or drug addiction: detection, intervention, treatment, and reentry. The fact that the Georgia Program has assumed a national leadership position can be credited significantly to the participation of these physicians' spouses.

In the detection of the impaired physician, the spouse is aware of the substance abuse problems long before anyone else knows the physician is having difficulty with alcohol or other drugs. In keeping with this important and critical element of early detection of impairment, the current president and president-elect of the Auxiliary requested an educational program for their members. Consequently, educational workshops have been conducted and scheduled in various counties throughout the state. A Disease Awareness List was prepared on small purse-sized plastic cards. This list was comprised of nine elements which can alert the spouse to the signs and symptoms of impairment in the physician (Table 1).

***"In the detection of the impaired physician, the spouse is aware of the substance abuse problems long before anyone else knows the physicians is having difficulty with alcohol or other drugs."***

Dr. Talbott is Program Director of MAG's Impaired Physicians Program, 4015 South Cobb Drive, Ste. 100, Smyrna, GA 30080. Send reprint requests to him.

Critical to the effectiveness of this list is the understanding that these symptoms and signs evolve over a period of time, that they appear singly and not necessarily sequentially as listed. They do not appear as a total grouping until later in this progressive disease. The myth that a physician's impairment is not serious and shouldn't be seriously considered until it interferes with patient care or occurs in the workplace is not only false but also potentially lethal. By the time the impairment is obvious in the workplace, the disease is in an advanced stage. The time for action and intervention is at the first opportunity for identification, and this is in the home with the spouse, significant others, or nuclear family. It is important for the spouse to understand that denial may prevent her or him initially from recognizing the role which alcohol and drugs are playing in creating the turbulence in their marriage. The fighting, the sexual problems, the extra-marital affairs, the inability to communicate, and the drifting apart are due to the alcohol and

drugs, not to business, finances, and stress. The Disease Awareness List brings into focus the impact of the disease of chemical dependence upon their marriage and the importance of using this list for early identification.

***"One of the components of the workshops being given to the Auxiliary is a film entitled, 'Intervention: Rescue from Destruction.'"***

Action and intervention are listed on the reverse side of the Disease Awareness List and entitled Action List (Table 2). Denial is a dynamic of the disease of chemical dependence and substance abuse. The impaired physician cannot reach out for help, partially because of ignorance of the disease and where to turn for help and partially because of the massive denial. Intervention in most cases is a necessary beginning to the recovery process. The spouse usually plays a very important role in the intervention. In the Georgia experience, the spouse and children have often played a critical part in the intervention process. Even when divorce or separation have occurred, spouses have effectively participated in the intervention. However, the spouse must have received adequate education as to the disease process of chemical dependence and have effectively dealt with her own anger and hostility, generated by her husband's alcoholism and/or drug dependence. Time and experience have taught that the spouse's participation is enhanced if she (or he) is but a part of the intervention team, which includes the children, partners, nurses, administrators, friends, and clergymen. Careful preparation, education, and role-playing by the intervention team, as a group, are the keys to success. Successful intervention leads to treatment. One of the components of the workshops being given to the Auxiliary is a film entitled, "Intervention: Rescue from Destruction."

**TABLE 1 — Alcohol/Drug Disease Awareness List**

- **Angry — abusive — depressed — change in mood and personality after alcohol and drugs**
- **Secretive — lying — hiding alcohol and drugs**
- **Withdraws from family activities — disappears and disappoints**
- **Sexual problems — impotent — affairs**
- **Abnormal behavior — withdraws from social life, community, church — changes friends**
- **Health-weight problems — needs medications — sleep disturbances and insomnia**
- **Office — hospital — patient problems**
- **Financial — legal — DUI problems**
- **Children's behavorial problems can be attributed to parent's alcohol and drug use**

**You don't have to have all of the symptoms listed above to have the disease.**

**TABLE 2 — Action List**

- **Document and list alcohol/drug incidents and evidence**
- **Express caring and disease awareness concern to spouse**
- **Call Regional Auxiliary Advocate member**
- **Discuss with other family members**
- **Go to Al-Anon meeting**
- **Call Impaired Physicians Committee for advice**
- **Participate and assist in intervention if necessary**

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**(404)435-2570**

Treatment for alcoholism and drug addiction in 1987 comprises many forms of therapeutic modalities, including inpatient and outpatient care, Alcoholics Anonymous/Narcotics Anonymous, counseling and interaction with the clergy, and/or a combination of these. Critical in all of these therapeutic modalities is the role of the spouse, be it husband or wife. Recovery for the alcoholic and drug addict must start with abstinence, but this in itself is far from achieving a contented and useful sobriety. Recovery is far more encompassing than just staying away from the destructive, mood-altering, addictive chemicals. Sobriety and recovery involve developing a new way of life, being able to cope with emotions such as anger, anxiety, and depression triggered by situations such as job stress, a difficult time in the marriage, problems with the children, death, divorce, bankruptcy, or a malpractice trial. For the physician to effectively handle these stresses, he/she must learn non-chemical coping skills. The spouse may be the most significant person, the critical factor, in this learning process. The Georgia IPP experience has

***"The Georgia IPP experience has taught us that providing the spouse with education and family therapy has been perhaps the most significant factor in the successful treatment and recovery of the sick physician."***

taught us that providing the spouse with education and family therapy has been perhaps the most significant factor in the successful treatment and recovery of the sick physician. Over the past decade, family therapy for the spouse has become more sophisticated and effective. Education as to the diagnosis of this psycho-social, biogenetic disease has become more intensified, as knowledge derived from research and delineation of data and statistics have characterized the illness. Once imparted to the spouse, the significant other, and then the children, it allows the impaired physician to more effectively develop his or her own non-chemical coping skills. In this process of recovery for the impaired physician, the spouse often experiences substantial emotional and personality growth. This personality development is extended to the children if they, too, are involved in the therapeutic recovery process of family therapy.

***"The myth that a physician's impairment is not serious and shouldn't be seriously considered until it interferes with patient care or occurs in the workplace is not only false but also potentially lethal."***

The impaired physician who is treated and successfully begins the recovery process may face his/her greatest challenge when he/she returns to the workplace. Reentry, as this is termed, may cause the returning impaired physician to feel anger, hostility, anxiety and uncertainty. Our experience has taught that anticipation and training for the stresses of reentry are critical to a successful recovery. Amelioration of these stresses is often accomplished by the spouse, who has been trained in family therapy to deal with these stresses. The spouse can act as a buffer for these disturbing emotional and situational responses which the reentering physician may encounter.

***"Since the inception of the IPP, the presidents and officers of the Auxiliary have assigned top priority to the Program."***

When the data were collected and analyzed for the first 500 physicians followed for a 4-year period after receiving treatment, inquiry was made as to the factors related to rate of relapse and inadequate treatment. One of the significant factors in the physician's relapse rate was the untreated or still sick spouse. These data clearly demonstrated the value and need for intensive family therapy. Additional data have likewise clearly indicated that the successfully treated impaired physician who has achieved sobriety has done so because of the helping and healing role of the spouse.

In my opinion, no activity of the Auxiliary to the MAG carries more impact or more profoundly influences the Medical Association's activities and thus the health of the Georgia community than the direct role of the spouse in MAG's Impaired Physicians Program. It is hoped that those county auxiliaries which have not yet had an IPP workshop are not yet aware of the Disease Awareness and Action List cards will call the telephone number listed on the cards (404-435-2570) and schedule a workshop for their members. The officers of the Auxiliary for the Medical Association of Georgia feel this to be a critical and very rewarding activity.


To understand much of what we're doing with respect to cancer research, you'd need a graduate degree in microbiology or biochemistry.

But to understand how well our educational programs and service resources help both patients and their families, simply talk to one out of every 100 Americans who are part of our volunteer program. Or talk to one of the 3 million who've survived cancer.

The battle isn't over but we are winning.

Please support the American Cancer Society.

# Highlights of MAG's 1987 Leadership Conference

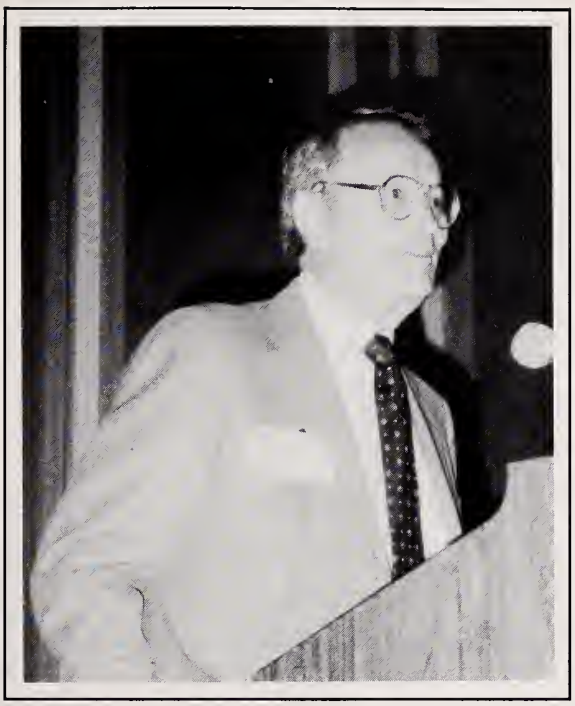
The Medical Association of Georgia's 1987 Leadership Conference has been hailed as the finest socioeconomic update for physicians recently held by any medical association. Our conference agenda, studded with speakers of national prominence, attracted over 330 physicians, auxilians and guests to Atlanta's Waverly Hotel, January 30-31.

*MAG'S PRESIDENT* ***John D. Watson, Jr., M.D.,*** *presided over the day-and-a-half meeting. In his opening remarks on Friday afternoon, Dr. Watson commended the audience for its interest in staying informed about "the critical socioeconomic trends and events that challenge us every day as we strive to practice the best medicine we can."*

*TWO SATISFIED attendees:* ***Dr. Bill Jarrett,*** *Atlanta ophthalmologist (left) asked us to take his picture. . .*

*A HIGHLIGHT of the Conference was Dr. Watson's formal commendation of Georgia's specialty societies and their presidents for their important contributions to organized medicine. In the audience listening was* ***Dr. Ellis Keener,*** *(left) Chairman of MAG's Committee on Specialty Society Relations.*

*A KEY PART of our Leadership Conference program featured three prominent spokesmen addressing the continuing challenge of high-quality patient care. At left, above, is* ***Arnold S. Relman, M.D.,*** *Editor of the* New England Journal of Medicine, *who spoke on the practitioner's traditional responsibilities for assuring good care. The doctor's responsibility to his or her patient, Dr. Relman emphasized, remains a moral imperative for physicians, regardless of government regulations or payor mechanisms.* ***Dr. Dennis S. O'Leary,*** *above, President of the Joint Commission on Accreditation of Hospitals, spoke on the Joint Commission's new initiatives in assuring quality of care, including its plan to provide outcome review in all the nation's accredited hospitals by 1990. On the left is* ***Sidney M. Wolfe, M.D.,*** *the Director of the Health Research Group of Ralph Nader's "Public Citizen" organization. Contending that the malpractice insurance crisis is actually a doctor-discipline crisis, Dr. Wolfe made sharp points about current procedures used to monitor physician competence and to discipline incompetent doctors.*



*IF YOU WERE at the Leadership Conference on Saturday afternoon, you'll remember how* ***Dr. Paul Ellwood*** *(left) and* ***Dr. Brant Mittler*** *(right) squared off and discussed the future of solo and small group private practices. Dr. Ellwood was the original proponent of HMO's and PPOs; Dr. Mittler is an outspoken opponent of "corporate medicine." During their exchange of opinions, Dr. Mittler's sharp points may have occasionally tested Dr. Ellwood's composure (which nevertheless remained outwardly calm), but they certainly heightened the audience's interest. It was a lively conclusion to a very successful meeting.*

*DR. JAMES A. KAUFMANN, long-standing Chairman of MAG's Council on Legislation, took a front-row seat during the Leadership Conference. On Saturday morning, he introduced State Representative Johnny Isakson of Cobb County, whom our attendees judged as one of the best speakers of the meeting.*

*PROFESSIONAL LIABILITY issues were emphasized during Saturday morning's session of the Leadership Conference program. Ross Rubin, Director of the American Medical Association's Legislative Division, spoke on tort reform at the national level. Following him, Sara Charles, M.D., Associate Professor of Clinical Psychiatry at the University of Illinois College of Medicine, explained the emotional stress suffered by physicians when they are sued. Here, during a break in the session, MAG Mutual's Chief Operating Officer* ***Tom Gose*** *discussed issues with MAG President-Elect,* ***Jack F. Menendez, M.D.,*** *(center) and MAG's Executive Director,* ***Michael R. Fowler*** *(right).*

# AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA 62nd ANNUAL MEETING

*Mrs. William C. Tippins, Jr.*
*President*
*Auxiliary to MAG*

## HYATT AT RAVINIA ATLANTA, GEORGIA

## APRIL 24-25, 1987

*Mrs. Charles W. Walden*
*President, Auxiliary to*
*DeKalb Medical Society*

It is my pleasure on behalf of the Auxiliary to the Medical Association of Georgia to welcome you to the Sixty-second Annual Convention of the House of Delegates at the Ravinia Hyatt in Atlanta. This meeting promises to be a treasure chest filled with a gentle mixture of business and pleasure. It will provide avenues of new ideas and inspirations, as well as recognition of accomplishments. It will give insight into the very heart of the organization. Annual convention makes it possible to meet new friends and greet long-standing ones.

Come dip heavily into the wealth of fellowship, partake of the business sessions and social activities, and renew the spirit of Auxiliary!

Welcome to the Annual Convention of the Auxiliary to the Medical Association of Georgia and to the beautiful Hyatt Ravinia Hotel! We hope you are going to enjoy springtime here in Atlanta and in the meetings and special activities we have planned for you. During your leisure time, excellent shopping at Perimeter Mall is available just across the street from our hotel. We in the DeKalb Auxiliary extend to each of you our warmest welcome; and, if there is anything our hostesses can do to make your stay more pleasant, please let us know.

# AUXILIARY PROGRAM

**THURSDAY, APRIL 23**

3:00 – 5:00 Registration and information

7:00 Opening Sessions of the MAG House of Delegates
A-MAG President's Report – Mrs. William C. Tippins, Jr.
AMA-ERF Check Presentation

**FRIDAY, APRIL 24**

9:00 – 5:00 Registration and information
Hospitality and Exhibits

10:00 PRE CONVENTION EXECUTIVE BOARD MEETING
(All former state presidents, state officers, state committee chairmen and members, county presidents and county presidents elect.)

12:00 AUXILIARY LUNCHEON
(Executive Board, Delegates, MAG Committee on Auxiliary and guests)

Greeting from A-AMA –
Mrs. Jean Hill (J. Edward)
A-AMA Regional Vice President

2:00 OPENING SESSION OF THE ANNUAL A-MAG HOUSE OF DELEGATES
- Call to Order
- Spotlighting County Presidents
- Opening Ceremonies
- President's Greetings
- Introductions
- Greetings from MAG President
- Special Address

BUSINESS MEETING
- Introduction of Pages
- Credentials Report
- Convention Standing Rules
- Adoption of Program
- Minutes
- Officers and Committee Reports
- Unfinished Business
- New Business
  - Bylaws & Handbook Revisions
- Announcements
- Recess of Meeting

EXHIBITION WALK
- County Exhibits, Scrapbooks, Doctors Day, Medical Heritage (Research & Romance of Medicine)

6:30 – 7:30 Auxiliary to MAG President's Reception
(Auxiliary Executive Board Members, MAG Committee on Auxiliary, Special Guests, and all auxilians)

**SATURDAY, APRIL 25**

9:00 – 12:00 Registration
Hospitality and Exhibits

9:00 SECOND GENERAL SESSION HOUSE OF DELEGATES
- Introduction of Guests
- Introduction of Past Presidents
- Message from Southern Medical Association Auxiliary
  - Mrs. Virginia Hopper (John) President, SMA-A
- Memorial Service

Business Continued
- Revised Credential Report
- Election of 1987-88 Nominating Committee
- Election of 1987 A-MAG Delegates for A-AMA Convention
- Report of Awards:
  - Achievement, AMA-ERF, Brawner Certificates of Excellence, Doctor's Day, Membership, Safety, Scrapbooks
- Report of 1986-87 Nominating Committee
- Election and Installation of Officers
- Presentation of 1987-88 President's Pin and Gavel
- Inaugural Address
- Presentation of Past President's Pin
- Announcements, Adjournment

12:30 LUNCHEON
(Newly installed state officers, outgoing officers, committee chairmen, committee members, county presidents, county presidents-elect, nominated presidents-elect, delegates alternates, auxiliary members and guests)

POST CONVENTION EXECUTIVE BOARD MEETING

PAST PRESIDENTS' LUNCHEON

# Medical Association of Georgia 1987 House of Delegates

## April 23 to April 26

Next month, the 133rd annual meeting of the Medical Association of Georgia House of Delegates, our policy-making body, will be held in Atlanta at the Hyatt Ravinia Hotel, located north of the city at Interstate Highway 285 and Ashford-Dunwoody Road.

The House of Delegates is MAG's legislative body, charged by our Constitution with the responsibility for transacting all business of the Association. Most importantly, the House determines MAG's positions on current issues facing the medical profession in Georgia.

All members of the Medical Association of Georgia are cordially invited to attend the several sessions of our House and, with their elected Delegates and Alternate Delegates, to participate in discussion of the issues under consideration.

### RESERVATIONS FOR LODGING

Guest rooms at the Hyatt Ravinia Hotel are available for participants in our House meeting. All MAG delegates and officers have received reservation cards from MAG headquarters. All others must make reservations directly with the Ravinia reservations staff, preferably by calling the hotel at 404/395-1234. For this meeting MAG has secured a discounted room rate of $85 single and $100 double occupancy per night.

The Auxiliary to the MAG will hold its 62nd Annual Meeting at the Hyatt Ravinia Hotel, April 24-25. Please refer to page 199 for program information.

### REGISTRATION

A registration desk will be maintained in the Ballroom foyer of the Ravinia for delegates, alternate delegates, directors, and all members. The registration desk will be open:

Thursday,
April 23 . . . . . 4:00 p.m.-8:00 p.m.
Friday,
April 24 . . . . . 7:30 a.m.-3:00 p.m.
Saturday,
April 25 . . . . . 8:30 a.m.-4:00 p.m.

### THURSDAY, APRIL 23 GENERAL SESSION

The opening General Session will be called to order by MAG President John D. Watson, Jr., M.D., on Thursday, April 23, at 7:00 p.m. in the Ballroom.

After opening ceremonies, Dr. Watson will present MAG Certificates of Appreciation to members who have made special contributions to MAG, and also to other citizens who have distinguished themselves in service to the medical profession in Georgia. The President will also honor MAG's members who have been in practice for 50 years or longer; those who have been awarded life membership; and those members who have died during the past year.

Special events during this opening session will be the address of our distinguished Guest Speaker and the report of the Auxiliary to the Medical Association of Georgia by its President, Mrs. William C. Tippins, Jr. Following will be the presentation of MAG's four special awards:

- Hardman Cup—presented to an individual for an outstanding discovery in medicine or surgery, or solution of a major problem in public health;
- Distinguished Service Award—for meritorious service reflecting credit and honor to the Association;
- Civic Endeavor Award—for outstanding public service and participation in civic activities;
- Family Physician of the Year—the recipient of this award is determined by the Board of Directors of the Georgia Academy of Family Physicians.

### FIRST SESSION OF THE HOUSE THURSDAY EVENING

After these ceremonies, James A. Kaufmann, M.D., Speaker, will convene the House of Delegates at 8:00 p.m. in the Ballroom.

The order of business will include:

- Nomination of candidates for MAG officers, AMA delegates and alternates.
- Announcement of Reference Committees for Friday.
- Introduction of resolutions or other new business.

## FRIDAY, APRIL 24

## GaMPAC BREAKFAST

MAG's Georgia Medical Political Action Committee, GaMPAC, will sponsor a champagne breakfast on Friday morning, April 24, at 7:30 a.m. in the Ballroom.

## REFERENCE COMMITTEES

According to the Bylaws of the Association, all resolutions and reports submitted by MAG officers, members, county societies, or committees which contain recommendations must be referred to a Reference Committee for open hearing.

All **MAG members are invited to the Hyatt Ravinia Hotel and encouraged to appear and express their views before the Reference Committees.** The Committees will open their hearings on Friday, April 24, at 9:00 a.m.

Our House customarily features 6 Reference Committees, each with an agenda of somewhat related issues:

- Reference Committee A (Maplewood "B" Room): socioeconomics
- Reference committee B (Maplewood "A" Room): medical practice
- Reference committee C (Camellia Room): legislation
- Reference committee D (Azalea Room): medical education
- Reference committee F (Oakwood "B" Room): MAG's budget
- Reference Committee C&B (Oakwood "A" Room): Constitution and Bylaws

## SATURDAY, APRIL 25 SECOND SESSION

The Second Session of the House of Delegates will convene at 9:00 a.m. on Saturday, April 25, in the Ballroom.

Principal item of business will be consideration of reports submitted by the several Reference Committees. The Delegates' vote on each of the numerous resolutions and recommendations brought before the House will help establish MAG's official policies.

*The Hyatt Regency Ravinia*

Dr. Watson, President, and MAG President-Elect, Jack F. Menendez, M.D., will address the House in the morning session. A special feature will be the address by our 1987 House of Delegates Keynote Speaker, William W. Moore, Jr., M.D., President of the Southern Medical Association.

Election of officers nominated on Thursday evening will take place during the Saturday morning session. The Tellers will pass out, collect, and count the ballots, and the results will be announced before the lunch break. All newly elected officers will be installed during the afternoon session on Saturday.

## PRESIDENT'S RECEPTION

The MAG will honor our President, Dr. John D. Watson, Jr., at a reception and dance beginning at 7:00 p.m., Saturday evening, in the Ballroom. All MAG members and their guests are invited.

## SUNDAY, APRIL 26

In the event that all Reference Committee reports are not acted upon in Saturday's session, the House will be convened at 9:00 a.m., Sunday.

# About Our New Speaker and Vice-Speaker

*JAMES A. KAUFMANN, M.D.*

*JACK A. RAINES, M.D.*

This year's 133rd annual session of the MAG House of Delegates will have two new presiding officers, elected last spring for 3-year terms. James A. Kaufmann, M.D., and Jack A. Raines, M.D., are familiar figures to the medical community in Georgia. We are pleased to have them assume the leadership of our Association's legislative body.

Before his installation as Speaker at the close of last year's House of Delegates, Dr. Kaufmann served as Vice-Speaker. A member of MAG and the Medical Association of Atlanta since 1952, he has chaired MAG's Legislative Committee for the past 14 years and has served on the Association's Executive Committee and Board of Directors for the past 8. Dr. Kaufmann, a graduate of the University of Tennessee College of Medicine, performed his internship and residency in medicine at Emory and in Boston and Louisville. He has practiced internal medicine and cardiology in Atlanta since 1952.

Dr. Raines is also an alumnus of the University of Tennessee College of Medicine. After several years of general practice in Memphis, he completed residency in psychiatry at St. Louis. Thereupon he moved to Columbus, and is in the private practice of office psychotherapy. Dr. Raines has served as president of the Muscogee County Medical Society and president of the Georgia Psychiatric Association. As a member of the MAG Board of Directors from 1968, he has held the positions of Chairman and Vice Chairman. Dr. Raines also serves on the Board of Directors of MAG Mutual Insurance Company.

We are delighted to have these two esteemed physicians assume leadership of our Association's House, and congratulate Drs. Kaufmann and Raines as they prepare to exercise their new responsibilities. ■

## THE SCHEDULE AT A GLANCE . . .

## MAG HOUSE OF DELEGATES
## APRIL 23-26, 1987
## HYATT RAVINIA HOTEL
## ATLANTA

### THURSDAY, APRIL 23

4:00-7:00 REGISTRATION (Ballroom Foyer)

7:00-8:00 GENERAL SESSION (Ballroom)
Presiding: John D. Watson, Jr., M.D.
President

Opening Ceremonies
Report of the President of the Auxiliary to the MAG, Mrs. William C. Tippins, Jr.
Presentation of MAG Awards
Recess

8:00-10:00 HOUSE OF DELEGATES, FIRST SESSION (Ballroom)
Presiding: James A. Kaufmann, M.D., Speaker

Nominations for Association Officers and AMA Delegates or Alternates
Introduction of New Business
Recess

### FRIDAY, APRIL 24

7:30 a.m. REGISTRATION (Ballroom foyer)

7:30 a.m. GaMPAC BREAKFAST (Ballroom)

9:00-3:00 REFERENCE COMMITTEE HEARINGS (Azalea, Camellia, Maplewood and Oakwood Rooms)

### SATURDAY, APRIL 25

8:30 a.m. REGISTRATION (Ballroom foyer)

9:00 a.m. HOUSE OF DELEGATES, SECOND SESSION (Ballroom)
Presiding: James A. Kaufmann, M.D., Speaker and Jack A. Raines, M.D., Vice Speaker
Election of Officers
Address of the President, Dr. Watson
Address of the President-Elect, Dr. Menendez
Report of Reference Committees
Keynote Address: William W. Moore, Jr., M.D.
President, Southern Medical Association
Announcement of Election Results

7:00 p.m. PRESIDENT'S RECEPTION AND DANCE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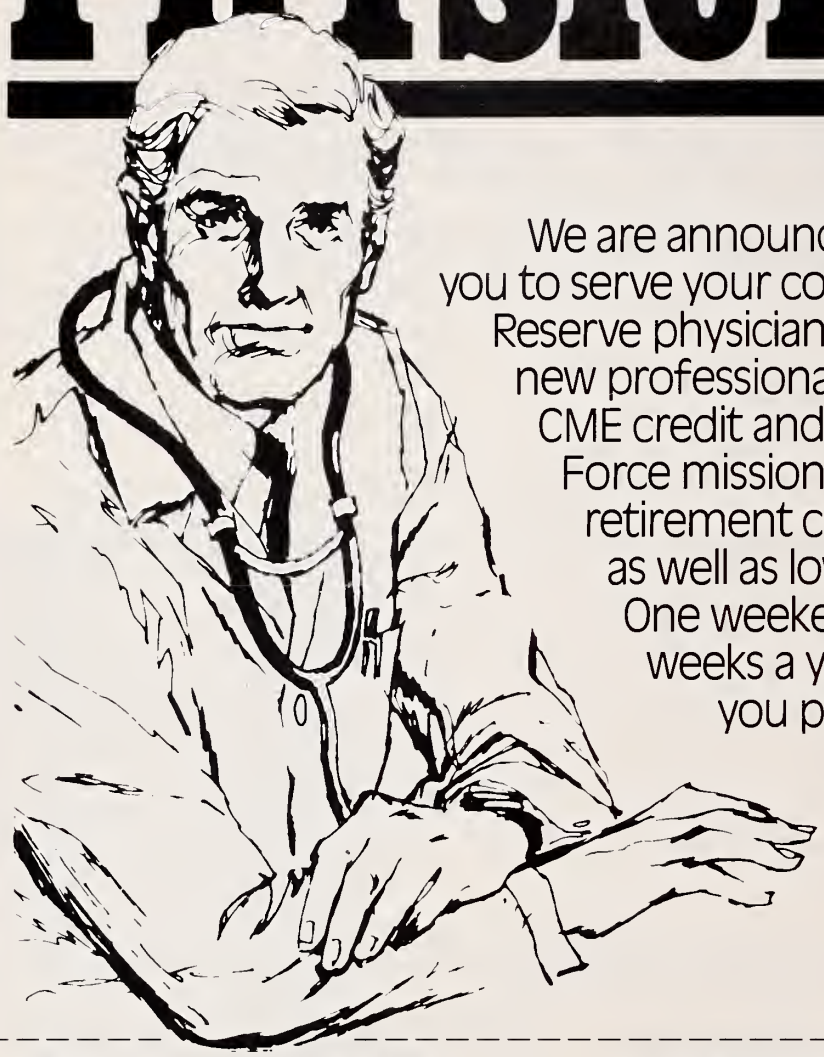

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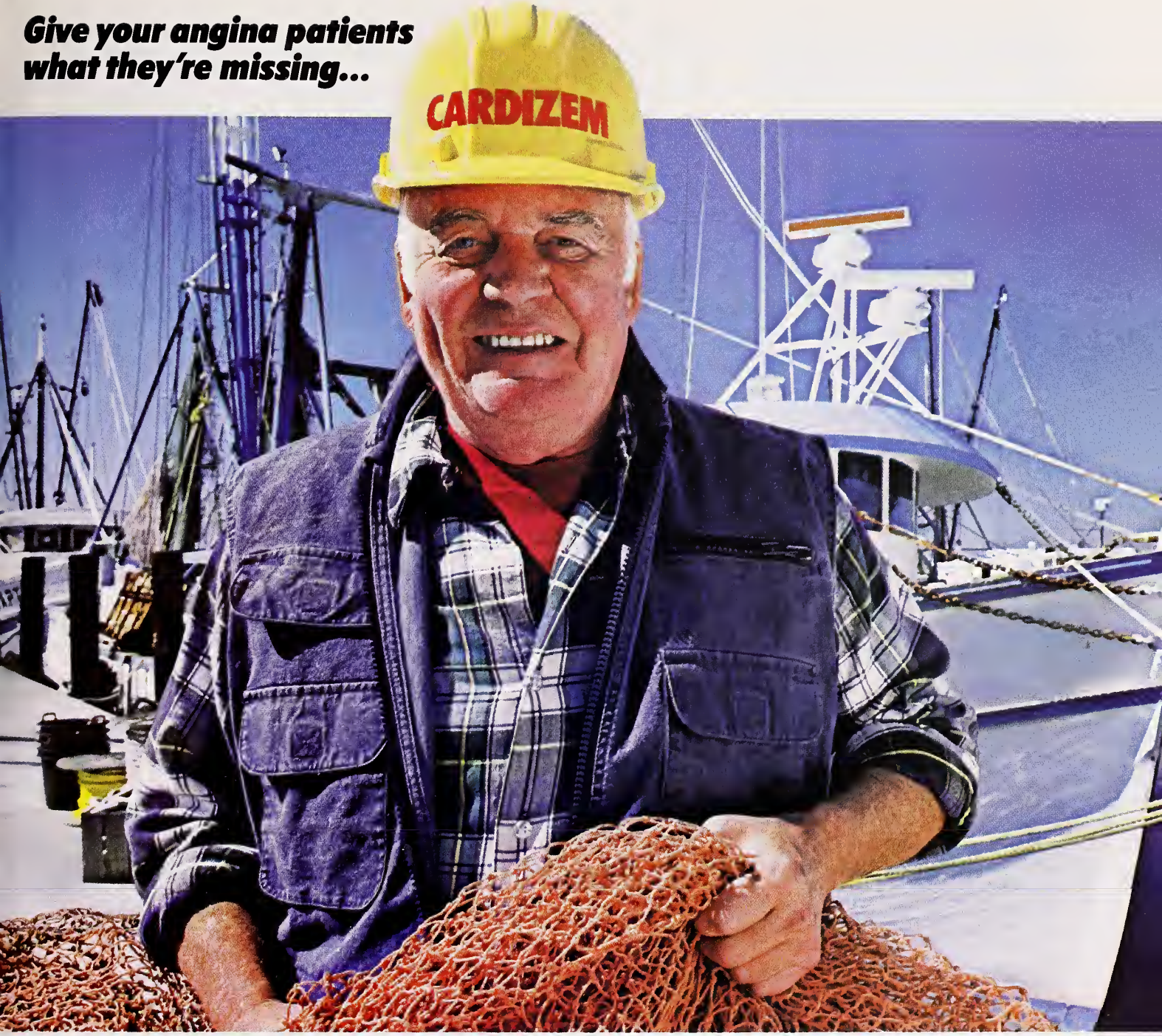


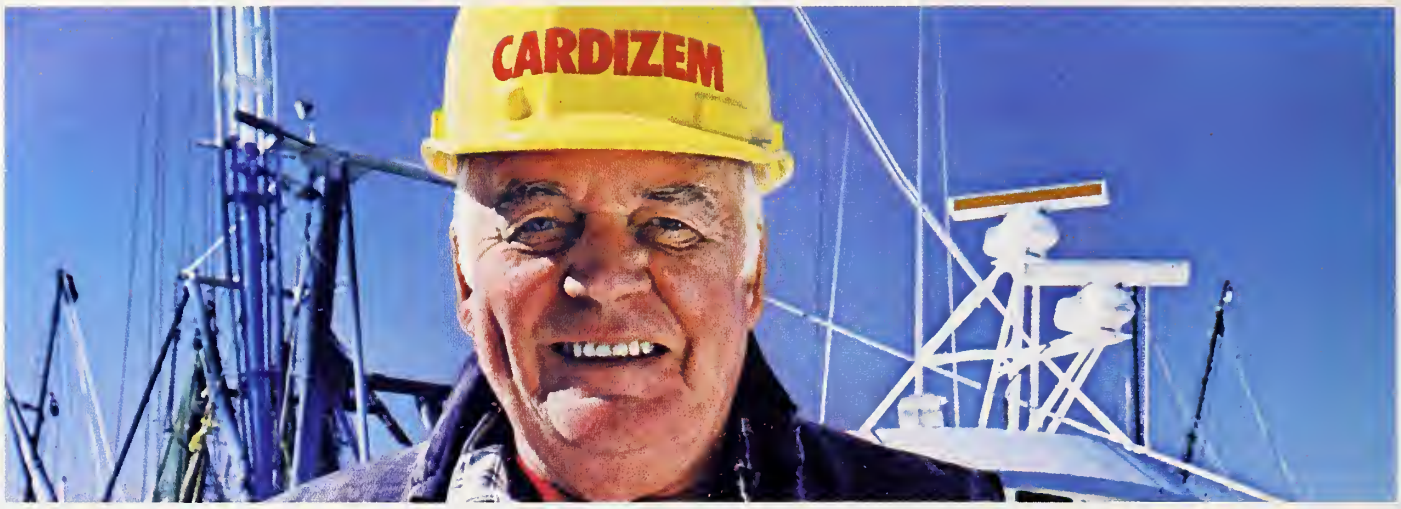

# CARDIZEM®: FEW SIDE EFFECTS

diltiazem HCl/Marion

- ***Antianginal action includes dilatation of coronary arteries, a decrease in vascular resistance/afterload, and a reduction in heart rate***
- ***Proven efficacy when used alone in angina[1]***
- ***Compatible with other antianginals[2,3*]***
- ***A safe choice for angina patients with coexisting hypertension, asthma, COPD, or PVD[4,5]***

***See Warnings and Precautions.**

*Please see brief summary of prescribing information on the next page.*




# CARDIZEM® FEW SIDE EFFECTS IN ANTIANGINAL THERAPY

diltiazem HCl/Marion

60 mg tid or qid

**Brief Summary**
Professional Use Information

**CARDIZEM®**
(diltiazem HCl) 30 mg and 60 mg Tablets

**CONTRAINDICATIONS**
CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

**WARNINGS**

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

**PRECAUTIONS**
**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.
**Drug Interaction.** Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)
Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.
**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.
**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.
There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.
**Nursing Mothers.** Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.
**Pediatric Use.** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS**
Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.
In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.
The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

| | |
|---|---|
| Cardiovascular: | Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope. |
| Nervous System: | Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor. |
| Gastrointestinal: | Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase. |
| Dermatologic: | Petechiae, pruritus, photosensitivity, urticaria. |
| Other: | Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties. |

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. Issued 7/86
See complete Professional Use Information before prescribing.

**References: 1.** Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers. Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983; 106(6):1341-1347. **2.** Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984;24(Dec):150-159. **3.** Johnston DL, Lesaway R, Human DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687. **4.** Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. **5.** Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.

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# THE BUSINESS OF LEGISLATION

*"If medicine is your profession, legislation should be your business!" Legislation has truly become a year-round "business" for Auxiliary members of the Medical Association of Georgia.*

Beginning with the Auxiliary Annual Meeting in the Spring, we report on the medical legislation passed and defeated in the recently completed General Assembly. Then, we attempt to predict what bills concerning medicine will be addressed for the coming year.

July brings the Auxiliary Summer Executive Board Meeting, where Legislative Workshops are held to educate our members in the legislative process, acquaint them with issues, and sharpen their lobbying skills. This is followed with a Legislative Weekend in August for MAG members, auxilians, and various state senators and representatives.

In the early Fall, all county auxiliaries gear up their individual campaigns for contacting and getting to know the legislators in their own districts. In an election year, auxilians are encouraged to learn the platforms of each candidate in their district and to work early on for the candidates of their choice. After the election, "key contacts" are formed, matching auxiliary members to legislators in their districts.

Of course, the forty (40) days of the General Assembly, January through March, mark the culmination of our legislative year. In 1987, the Auxiliary to the Medical Association of Georgia joined hands with the PIP Program (Physicians Involvement Program). Through SIP (Spouse Involvement Program), each county auxiliary was urged to select one or more days to visit the General Assembly. These individual groups met first at the PIP office in the Ramada Capitol Plaza for briefing by MAG staff on impending legislation and predicted major events of the Assembly for that day. The groups observed the Assembly from the public galleries, contacted their individual legislators, and, in most cases, took them to lunch afterwards to discuss forth-coming medical bills. Our goal was to have auxilians from around the state at the Capitol every day of the Session.

In addition to our efforts in state legislation, this year we have been asked by the AMA-A National Legislative Committee to organize phone banks at the grass roots level. This involves recruiting auxiliary volunteers to gather at a central location and call all the physician homes in the district, briefing them as to a pending vote of national importance to medicine. Physicians and spouses, in turn, are urged to contact their U.S. Congressmen and Senators immediately concerning action.

As we look back on legislation in 1987, we see a very positive note of increasing involvement on the part of physicians and auxilians in the legislative process. Indeed, legislation *must* become our business if we are to advise and educate our lawmakers successfully in positive health care legislation.■

***Jan Collins***
***Legislative Chairman***
***A-MAG***

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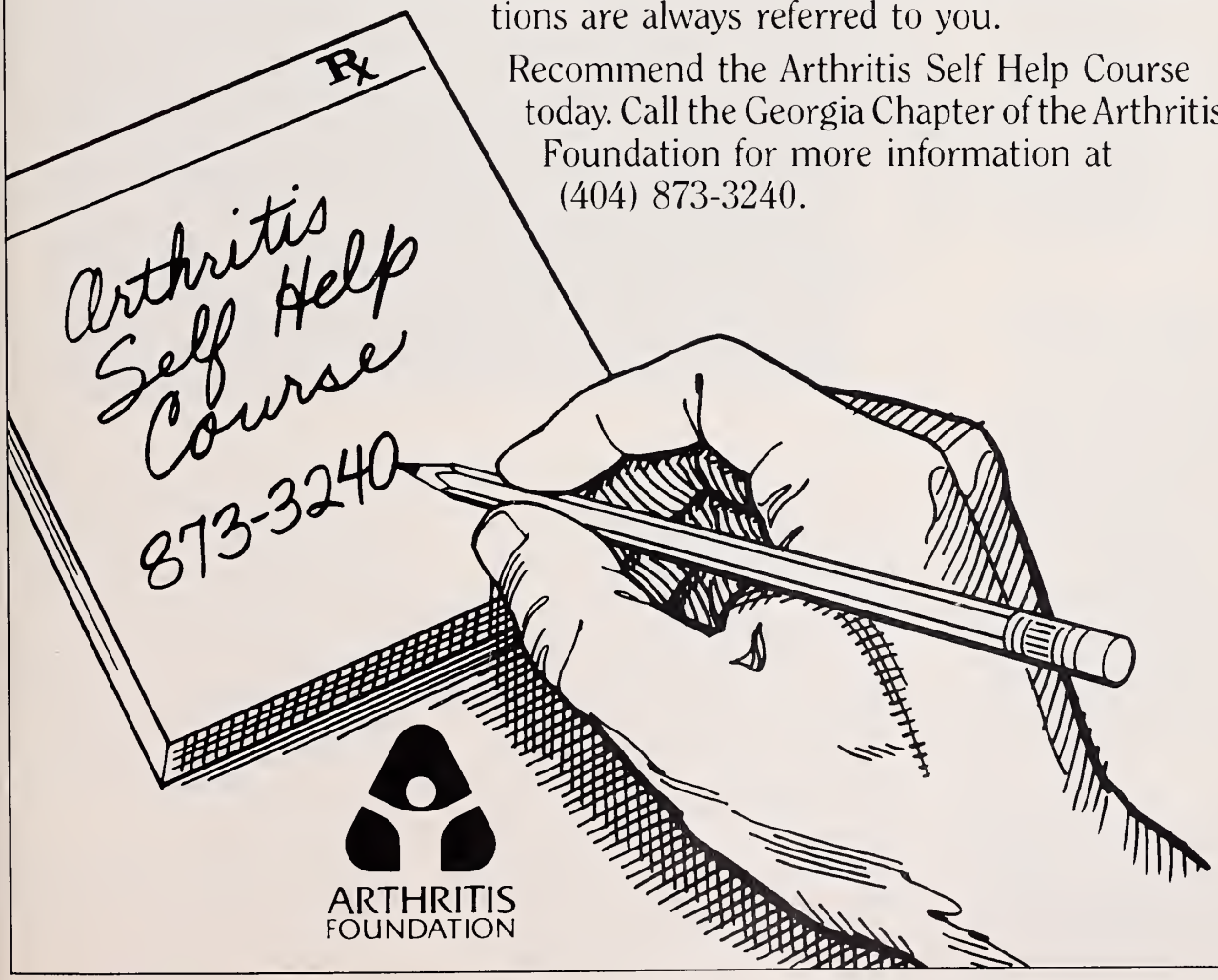


ARTHRITIS FOUNDATION

# Heart Transplantation in Georgia: The Emory Experience

*Douglas A. Murphy, M.D., William D. Knopf, M.D., Joane H. Goodroe, R.N.*

ALTHOUGH the first heart transplant in this country was performed in 1967, it has required nearly 20 years for the procedure to mature from an experimental to a routine form of treatment. This transition occurred largely due to the efforts of workers at Stanford University and to the introduction in 1980 of the new and effective immunosuppressant, cyclosporine. One-year survival following heart transplantation increased from 20% in 1968 to 80% in 1985, and the number of transplants performed across the country increased dramatically, with 962 performed in 1985.[1]

Heart transplantation involves two groups of patients, transplant recipients and heart donors. The transplant recipients are young patients with severe heart failure caused by primary cardiomyopathy or multiple myocardial infarctions. These patients are otherwise healthy and frequently in the prime of their lives. Their survival with conventional medical therapy can be measured in days to several months. General criteria for heart transplant recipients are depicted in Table 1, while frequent contraindications are listed in Table 2.

**TABLE 1 — General Criteria For Cardiac Transplantation**

1. *Severe isolated heart disease.*
2. *One year survival less than 20%.*
3. *No conventional therapy available.*

**TABLE 2 — Contraindications To Cardiac Transplantation**

1. **Over 60 years old.**
2. **Severe pulmonary hypertension.**
3. **Severe irreversible hepatic or renal dysfunction.**
4. **Active systemic infection.**
5. **Insulin dependent diabetes mellitus.**
6. **Inability to follow a strict medical regimen.**

The second group, the heart donors, is not as familiar to most clinicians. These patients are young people who have suffered fatal brain injury usually in accidents or suicide attempts but occasionally by spontaneous cerebrovascular accidents. When the brain stops functioning entirely, spontaneous respiration ceases, and hypoxemia results in cardiac arrest. Some patients with fatal brain injury reach medical attention before respiration ceases and, by support of a mechanical ventilator, their other organs can be kept functioning for several days. By meeting state and institutional guidelines for brain death and with the consent of the victim's family, such patients may become organ donors.

When a heart donor is identified, the most appropriate recipient is selected on the basis of weight, blood type, and immunologic compatibility to the donor's tissue. Recipients who are hemodynamically unstable are given the highest priority. A surgical team is dispatched to the donor hospital where brain death and consent for organ donation are verified. The

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donor heart is then removed by dividing the great vessels at their pericardial reflections, and the heart is preserved by cold intracoronary and topical saline solutions during its transport back to the recipient's hospital.

Simultaneous to the procurement of the donor heart, the recipient is anesthetized and a heart-lung machine is prepared and connected to the recipient's great vessels to support circulation during the transplant. When the donor heart arrives safely, the recipient's diseased heart is excised, leaving cuffs of the right and left atria, aorta, and pulmonary artery. These cuffs are then sutured to the respective cuffs of the donor heart as depicted in Figure 1. Preservation time from removal of the donor heart to restoration of coronary blood flow in the recipient's chest may extend 4 hours with good graft function.

Postoperatively, heart transplant patients are managed in a fashion similar to conventional heart surgery patients, except that reverse isolation is used to reduce the rate at which they are colonized with nosocomial bacteria. Immunosuppression is routinely accomplished with cyclosporine, prednisone, and azathioprine. Rejection of the allograft heart is monitored closely by right ventricular endomyocardial biopsies performed percutaneously via the jugular vein. Clinical signs of congestive heart failure and low electrocardiographic voltage are very late manifestations of rejection in cyclosporine-treated patients, and rejection can only be reliably assessed by biopsy.[2] Episodes of rejection are managed with increased steroid administration and, in severe cases, with administration of rabbit antithymocyte globulin. Signs of infection are aggressively evaluated and treated. Infection appears to occur less frequently with cyclosporine than with previous immunosuppressive regimens relying on high doses of steroids. This reduction is most marked in infections caused by opportunistic organisms such as fungi and parasites.

Survival at large centers is approximately 80% at 1 year and 70% at 3 years.[3] The long-term

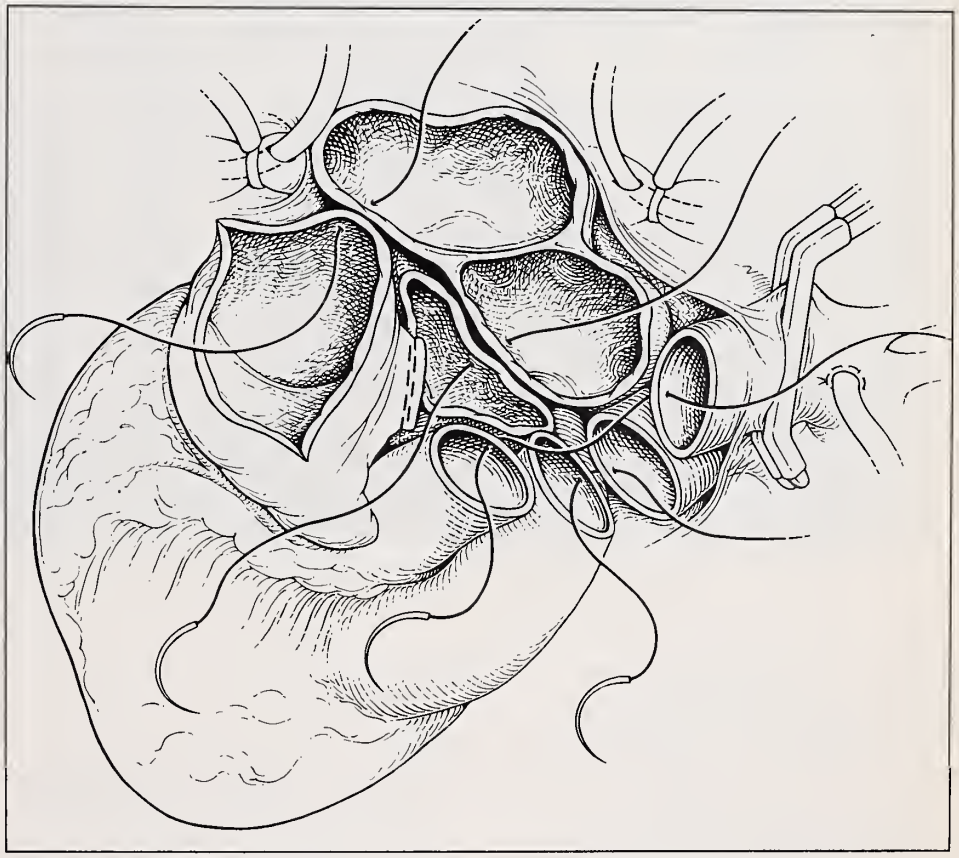

*Figure 1. Surgical technique of cardiac transplantation.*

*Figure 2. First 18 consecutive heart transplant patients at Emory University Hospital.*

survival of transplanted patients maintained on cyclosporine cannot yet be assessed. Late deaths occur as a result of chronic rejection manifested as a restrictive cardiomyopathy due to fibrosis or as a diffuse obliteration of the coronary arteries. When graft failure occurs, retransplantation with a new donor heart can be performed, with results comparable to patients undergoing transplantation for the first time. Since fatal acute rejection or infection can still occur after years of stable allograft function, continued close medical follow-up is necessary.

Functionally, transplant patients lead near-normal lives. The transplanted heart beats in a denervated state at a sinus rate of 90 to 120 beats per minute. With exercise, cardiac output increases initially by increased venous return and then by enhanced contractility as circulating catecholamines increase. Despite the need for immunosuppression and continued medical surveillance, heart transplant patients may be physically active and many return to full employment.

### The Emory Experience

A program of cardiac transplantation was undertaken at Emory University Hospital in April, 1985. During the first 18 months of the program, 65 patients were accepted as candidates for transplantation. Thirty-one patients underwent 32 transplants, 15 patients died waiting for donors, and 18 patients remain on the waiting list. The transplanted patients include 27 males and 4 females ranging in age from 27 to 59 years. Indications included dilated cardiomyopathy (17), ischemic cardiomyopathy (11), aortic valve disease (2), cardiac amyloidosis (1), and chronic rejection (1). Nine patients had undergone previous cardiac surgery. Fourteen patients were dependent on intravenous inotropic drug support at the time of transplantation, and five were intraaortic balloon-pump dependent. Average waiting period for an appropriate donor was 82 days for stable patients and 39 days for

critically ill patients. Donor heart ischemic time averaged 105 minutes for local procurements and 162 minutes for regional and distant procurements. Postoperative hospitalization following transplantation averaged 26 days, ranging from 14 to 82 days.

***"During the first 18 months of the cardiac transplantation at Emory University Hospital, 65 patients were accepted as candidates for transplantation."***

Twenty-eight patients have experienced at least one episode of mild to moderate rejection, with resolution following increased steroid treatment. Severe rejection episodes requiring inotropic support developed in two of 31 patients during the first month following transplantation. One of these patients responded to pulse therapy with methylprednisolone, and one required treatment with intravenous rabbit antithymocyte globulin.

Infectious complications developed in 24 of the 31 patients over the 18-month study period. The majority of infections were clinically insignificant mucocutaneous herpes infections. Several patients developed reactivation of latent cytomegalovirus infections. Life-threatening infections occurred in eight patients, involving pulmonary infection in seven patients, four with bacteria and three with fungi. One patient experienced a pancreatic abscess. One patient with a fungal lung infection developed a metastatic brain abscess which is still being treated.

Cyclosporine-related acute renal failure necessitated temporary postoperative ultrafiltration in three patients. Hypertension related to cyclosporine administration has required chronic antihypertensive therapy in 24 patients.

At the end of the first 18 months, there were no operative, hospital, or late deaths, with a mean follow up of 265 days ranging from 20 to 545 days. The 18 patients transplanted during the first year of clinical transplantation are shown in Figure 2.

### Future Considerations

Cardiac transplantation has clearly been shown to be an excellent form of palliative therapy for selected patients with severe isolated heart disease. The major limitation to cardiac transplantation at Emory University Hospital and throughout the country has been a shortage of donor hearts. The present deficiency of organs is a manifestation of the fact that in the United States, only 15 to 20% of brain dead potential organ donors actually become donors.[4] This failure is caused both by a failure of the medical profession to pursue organ donation and by unwillingness of the donor families to donate. It is hoped that by more education of both the medical community and the general public that enhanced organ donation will occur.

***"The present deficiency of organs is a manifestation of the fact that in the United States, only 15 to 20% of brain dead potential organ donors actually become donors."***

It is important to recognize that even with near 100% organ donation, heart transplantation offers therapy to only a select group of patients with severe heart failure. If criteria are relaxed to include older patients and those with associated conditions, such as diabetes, a much larger group of patients estimated at 17,000 to 35,000 per year could benefit by such intervention. However, with a finite number of human organs available, further transplantation could onlly occur by use of another primate species. At the present time, the complexities of the immunologic differences between primate species and the potential infectious risks associated with the use of xenografts make the prospect of a new, unlimited source of donor organs unlikely in the near future.

The plight of this large group of patients is stimulating significant research and development into artificial ventricular assist and total heart devices. Multiple engineering problems must be solved, including issues of durability, thrombogenicity, and energy, before widespread clinical application can be considered. Temporary use of ventricular assist devices or the total artificial heart as a "bridge to transplantation" in selected transplant candidates represents an important research step in the eventual development of permanent heart replacement devices.

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Research works.
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# Bone Marrow Transplantation

*Roger A. Vega, M.D.*

BONE MARROW TRANSPLANTATION (BMT) has become an effective therapy for a number of lethal congenital disorders and acquired malignant diseases of the hematopoietic and lymphoid system. Using supralethal chemotherapy and/or radiation therapy, this technique allows the body to replenish pleuripotential stem cells which may have been congenitally absent or destroyed by malignancy. Table 1 lists current applications of BMT.

The major developmental breakthrough which made the BMT technique possible was the recognition of the human lymphocyte antigen (HLA) system and the major histocompatibility complex in man.[1] Recent advances in the BMT technique have been possible by a better understanding of chemotherapy, radiotherapy, and the improvement of the intensive support systems.

## Categories of Bone Marrow Transplantation

Bone marrow transplantation can be divided into three categories:

a) Autologous: the patient's own bone marrow is frozen, once in remission, to be used later in the course of treatment.

b) Syngeneic: the donor bone marrow comes from an identical twin.

c) Allogeneic: the bone marrow donor is an HLA-matched relative, usually a sibling.

Bone marrow transplantation is based on the matching of the HLA system, which is inherited by Mendelian principles. The possibilities of having an identical HLA-matched sibling is one in four or 25%.[2]

**TABLE 1 — Bone Marrow Transplantation Applications**

| |
|---|
| *Congenital* |
| **Severe Combined Immunodeficiency (SCI)** |
| **Wiscott-Aldrich** |
| **Paroxysmal Nocturnal Hemoglobinuria** |
| **Infantile Osteopetrosis** |
| **Fanconi's Anemia** |
| **Hurler's** |
| **Thalassemia Major** |
| *Acquired* |
| **Acute Leukemia (ALL, ANLL)** |
| **Aplastic Anemia** |
| **Chronic Myelogenous Leukemia** |
| **Lymphoma** |
| **Neuroblastoma and Other Solid Tumors** |
| *Others* |
| **Sickle Cell Disease** |
| **Gaucher** |
| **Nieman Pick** |
| **Blackfan-Diamond Syndrome** |

Although simplistic in design, BMT is pardoxically a sophisticated and expensive technique. Bone marrow harvesting is performed under general anesthesia by extracting marrow cells from the donor's iliac crest. This requires multiple aspirations to remove the required number of cells for a successful engraftment (2-6 x $10^8$ nucleated cells x Kg).[3] The bone marrow is then filtered and given to the recipient by intravenous infusion.

## Clinical Stages

Bone marrow transplantation can be divided into five clinical stages: conditioning, engrafting, pancytopenia, early recovery, and convalescence.[4] Conditioning is the stage in which myeloablative therapy is given to the host in preparation to accept the graft. In the case of malignancies, this therapy is aimed at destroying and residual disease. The usual combination is chemotherapy and radiation therapy. The most common chemotherapeutic agents are cytoxan, cytosine arabinoside, and Bulsulfan. The radiation involves total body radiation (TBI). Engrafting consists of actual marrow transferral as described previously.

A period of pancytopenia follows for up to 6 weeks. This is the period of time required by the pluripotential stem cells to

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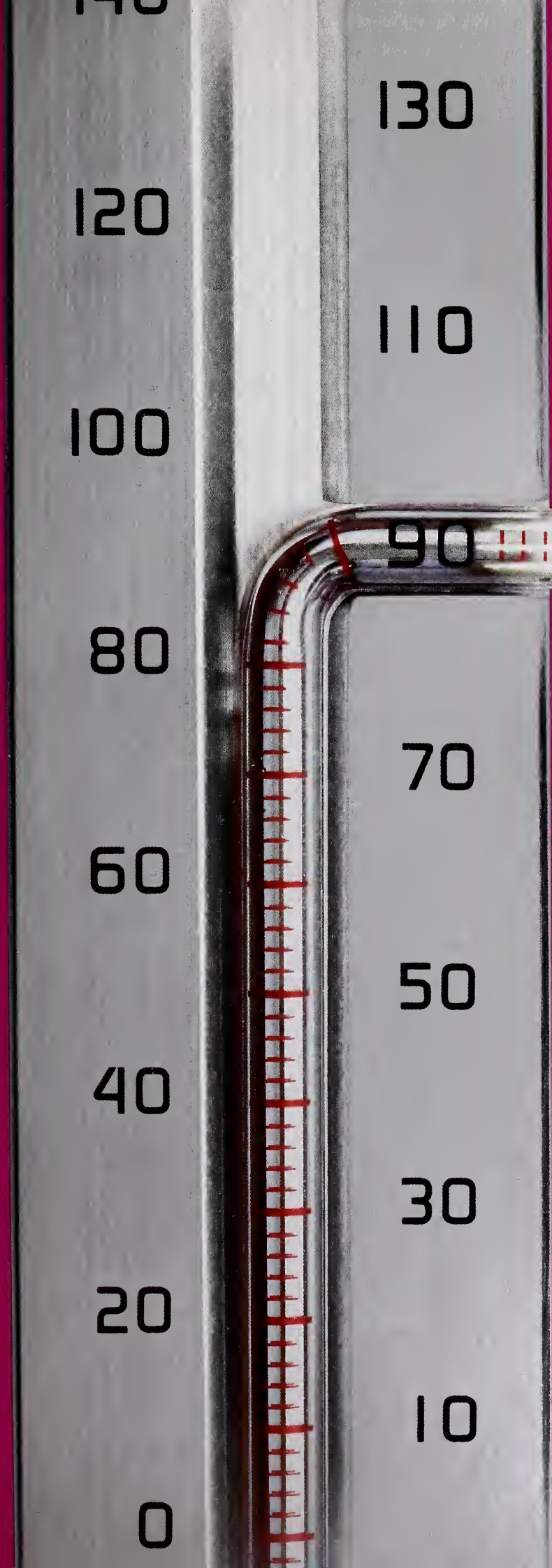
This paper was sponsored by the Georgia Division of the American Cancer Society. Those wishing to contribute papers to the CANCER section should send them to Thomas W. Phillips, M.D., CANCER Section Editor, 25 Prescott St., Atlanta, GA 30365.



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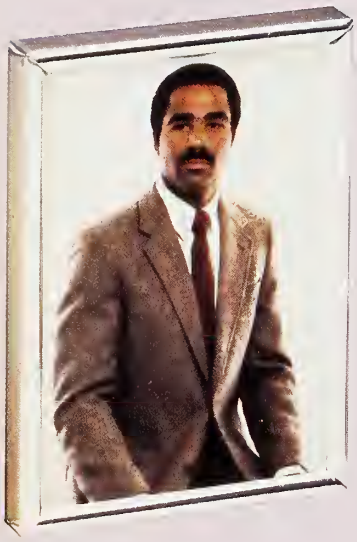

**JAMES B.**
38, black male, heavy smoker. Prescribed a diuretic by another physician last year for hypertension.

**YOUR CONCERNS**
Presents with "smoker's cough." Workup reveals a BP of 150/107.

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ISOPTIN® (verapamil HCl/Knoll) because...
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**ALICE W.**
65, diabetic, overweight. Her BP has elevated to 190/98.

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She's on daily insulin.

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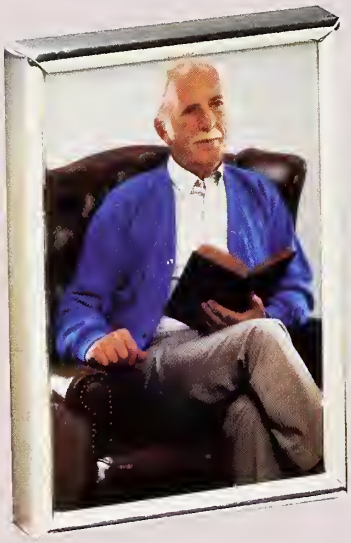

**THOMAS G.**
70, asthmatic. In the past, BP adequately controlled with 25 mg hydrochlorothiazide daily.

**YOUR CONCERNS**
Today patient presents with symptoms of gout. Workup reveals high uric acid level, low serum potassium, and BP elevated to 180/98.

**A LOGICAL CHOICE FOR CONTROL OF HIS BP**
ISOPTIN® (verapamil HCl/Knoll) because...
— Unlike diuretics, ISOPTIN will not decrease serum potassium levels or elevate uric acid levels.
— Unlike beta blockers, ISOPTIN can be used safely in asthma and COPD patients.

**JOHN K.**
42, Annual physical uncovered diastolic BP of 102... confirmed on three successive office visits. Unresponsive to nonpharmacologic intervention.

**YOUR CONCERNS**
Salesman, spends many hours of his working day in car... total cholesterol level 300, HDL 35.

**A LOGICAL CHOICE FOR CONTROL OF HIS BP**
ISOPTIN® (verapamil HCl/Knoll) because...
— Unlike diuretics, ISOPTIN does not cause urinary urgency.
— Unlike either beta blockers or diuretics, ISOPTIN will not adversely affect his already seriously compromised lipid profile.
— Unlike with propranolol, fatigue and impotence are rarely reported.

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Brief Summary

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**RNINGS: Heart Failure:** ISOPTIN should be avoided in patients with severe left ventricular sfunction (see DRUG INTERACTIONS). Patients with milder ventricular dysfunction should, if ssible, be controlled before verapamil treatment. Hypotension: ISOPTIN (verapamil HCl) may oduce occasional symptomatic hypotension. Elevated Liver Enzymes: Elevations of transinases with and without concomitant elevations in alkaline phosphatase and bilirubin have en reported. Periodic monitoring of liver function in patients receiving verapamil is therefore udent. Accessory Bypass Tract (Wolff-Parkinson-White): Patients with paroxysmal and/or ronic atrial flutter or atrial fibrillation and a coexisting accessory AV pathway have developed reased antegrade conduction across the accessory pathway producing a very rapid ntricular response or ventricular fibrillation after receiving intravenous verapamil. While this s not been reported with oral verapamil, it should be considered a potential risk. Treatment is ually D.C.-cardioversion. Atrioventricular Block: The effect of verapamil on AV conduction and e SA node may cause asymptomatic 1st degree AV block and transient bradycardia. Higher grees of AV block, while infrequent (0.8%), may require a reduction in dosage or, in rare tances, discontinuation of verapamil HCl. Patients with Hypertrophic Cardiomyopathy ISS): Although verapamil has been used in the therapy of patients with IHSS, severe rdiovascular decompensation and death have been noted in this patient population.

**ECAUTIONS: Impaired Hepatic or Renal Function:** Verapamil is highly metabolized by the r with about 70% of an administered dose excreted in the urine. In patients with impaired patic or renal function verapamil should be administered cautiously and the patients nitored for abnormal prolongation of the PR interval or other signs of excessive pharcological effects (see OVERDOSAGE).

**ug Interactions:** Beta Blockers: Concomitant use of ISOPTIN and oral beta-adrenergic cking agents may be beneficial in certain patients with chronic stable angina or hypertension, t available information is not sufficient to predict with confidence the effects of concurrent atment in patients with left ventricular dysfunction or cardiac conduction abnormalities. italis: Clinical use of verapamil in digitalized patients has shown the combination to be well erated if digoxin doses are properly adjusted. However, chronic verapamil treatment increases um digoxin levels by 50 to 75% during the first week of therapy and this can result in digitalis icity. Upon discontinuation of ISOPTIN (verapamil HCl), the patient should be reassessed to id underdigitalization. Antihypertensive Agents: Verapamil administered concomitantly with l antihypertensive agents (e.g., vasodilators, angiotensin-converting enzyme inhibitors, retics, beta blockers, prazosin) will usually have an additive effect on lowering blood ssure. Patients receiving these combinations should be appropriately monitored. Disyramide: Disopyramide should not be administered within 48 hours before or 24 hours after apamil administration. Quinidine: In patients with hypertrophic cardiomyopathy (IHSS), ncomitant use of verapamil and quinidine resulted in significant hypotension. There has been eport of increased quinidine levels during verapamil therapy. Nitrates: The pharmacologic file of verapamil and nitrates as well as clinical experience suggest beneficial interactions. netidine: Two clinical trials have shown a lack of significant verapamil interaction with netidine. A third study showed cimetidine reduced verapamil clearance and increased nination to 1/2. Anesthetic Agents: Verapamil may potentiate the activity of neuromuscular cking agents and inhalation anesthetics. Carbamazepine: Verapamil may increase carnazepine concentrations during combined therapy. Rifampin: Therapy with rifampin may rkedly reduce oral verapamil bioavailability. Lithium: Verapamil may lower lithium levels in ient on chronic oral lithium therapy. Carcinogenesis, Mutagenesis, Impairment of Fertility: ere was no evidence of a carcinogenic potential of verapamil administered to rats for two rs. Verapamil was not mutagenic in the Ames test. Studies in female rats did not show paired fertility. Effects on male fertility have not been determined. Pregnancy (Category C): ere are no adequate and well-controlled studies in pregnant women. ISOPTIN crosses the cental barrier and can be detected in umbilical vein blood at delivery. This drug should be d during pregnancy, labor, and delivery, only if clearly needed. Nursing Mothers: ISOPTIN is reted in human milk, therefore, nursing should be discontinued while verapamil is ministered. Pediatric Use: Safety and efficacy of ISOPTIN in children below the age of 18 years e not been established.

**VERSE REACTIONS:** Constipation 8.4%, dizziness 3.5%, nausea 2.7%, hypotension 2.5%, ma 2.1%, headache 1.9%, CHF/pulmonary edema 1.8%, fatigue 1.7%, bradycardia 1.4%, AV block 0.8%, flushing 0.1%, elevated liver enzymes (see WARNINGS). The following ctions, reported in less than 1.0% of patients, occurred under conditions (open trials, rketing experience) where a causal relationship is uncertain; they are mentioned to alert the rsician to a possible relationship: angina pectoris, arthralgia and rash, AV block, blurred ion, cerebrovascular accident, chest pain, claudication, confusion, diarrhea, dry mouth, pnea, ecchymosis or bruising, equilibrium disorders, exanthema, gastrointestinal distress, gival hyperplasia, gynecomastia, hair loss, hyperkeratosis, impotence, increased urination, omnia, macules, muscle cramps, myocardial infarction, palpitations, paresthesia, psychotic nptoms, purpura (vasculitis), shakiness, somnolence, spotty menstruation, sweating, cope, urticaria. Treatment of Acute Cardiovascular Adverse Reactions: Whenever severe otension or complete AV block occur following oral administration of verapamil, the ropriate emergency measures should be applied immediately, e.g., intravenously administered isoproterenol HCl, levarterenol bitartrate, atropine (all in the usual doses), or calcium conate (10% solution). If further support is necessary, inotropic agents (dopamine or utamine) may be administered. Actual treatment and dosage should depend on the severity the clinical situation and the judgment and experience of the treating physician.

**ERDOSAGE:** Treatment of overdosage should be supportive. Beta-adrenergic stimulation or enteral administration of calcium solutions may increase calcium ion flux across the slow nnel, and have been used effectively in treatment of deliberate overdosage with verapamil. ically significant hypotensive reactions or fixed high degree AV block should be treated with opressor agents or cardiac pacing, respectively. Asystole should be handled by the usual asures including cardiopulmonary resuscitation.

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repopulate the marrow space. All patients require transfusions of irradiated packed red blood cells and platelets. All blood products have to be irradiated in order to prevent Graft-Versus-Host Disease (GVHD). At this stage, the patient is at the highest risk of developing bacterial and fungal septicemia. Most of the infections occur either by reactivation or normal flora invasion. A protective environment, such as reverse isolation or sterile laminar flow room, protects from nosocomial infections. Ninety-eight percent of the patients will develop fever and will require broad spectrum antibiotic coverage.

***"Bone marrow transplantation provides a major therapeutic strategy for an increasing number of hematologic, immunologic, inherited, and metabolic disorders."***

Severe mucositis and diarrhea are common findings in this stage. The latter are side effects of the chemoradiotherapy. These patients require total parenteral nutrition and close surveillance of the acid/base system and electrolytes parameters.

The early recovery period follows the pancytopenia stage. It is characterized by the recovery of the peripheral blood counts. The usual order of reconstitution is white blood cells, red blood cells, and platelets. At this stage, irradiated packed red blood cells and platelets may be needed. The patients are still at risk for infections. Reactivations of CMV and *Pneumocystis carinii* interstitial pneumonitis may occur also. Trimethropin-sulfa is commonly used as a prophylactic agent against *P. carinii*. At the present time, there is no prophylactic agent for CMV. The interstitial pneumonitis carries a 40% mortality.[4]

The Graft-vs-Host Disease (GVHD) process is initiated with the engraftment of allo-reactive, mature T-lymphoyctes. Thirty to seventy percent matched transplanted patients develop some degree of GVHD. Twenty to thirty percent of the patients in whom GVHD develops will die.

GVHD is divided into acute and chronic phases. If the disease occurs within the first 100 days post transplant, it is considered acute. An onset or carry-over beyond 100 days post transplant is considered chronic.

The clinical manifestations of acute GVHD include maculopapular rash, hepatitis, and gastrointestinal manifestations (i.e., diarrhea). Chronic GVHD is characterized by a delay in the immunologic reconstitution, hepatic cirrhosis, and sclerodermatous changes of skin and joints.[5] The best treatment for this condition is prevention. Preventive agents, such as cyclosporine A, accompanied by either methylprednisolone or methotrexate, have been shown to be effective combinations. Once GVHD develops, the treatment consists of immunosuppressive drugs, such as high dose prednisone, cyclosporine, A and Imuran.

The final stage is the convalescent period in which the full bone marrow repopulation occurs. There is still a considerable risk of viral pneumonitis and encapsulated bacterial infections. The immune system of these patients is not considered fully recovered until a year later.

### Indications for Bone Marrow Transplantation

When and in which malignancies is a bone marrow transplant indicated? Patients with acute non lymphocytic leukemia (ANLL) receiving chemotherapy may have an induction-remission rate of 85% but only 15-20% 5-year survival. Allogeneic bone marrow transplant is indicated in ANLL patients at their first remission if they have an

HLA matched donor. The 2-year survival rate of these patients transplanted in their first remission may be 40-60%.[7] The success rate of ANLL transplanted in relapse is approximately 15-20%.

> ***"The major developmental breakthrough which made bone marrow transplantation possible was the recognition of the human lymphocyte antigen system and the major histocompatibility complex in man."***

Aplastic anemia is a total bone marrow failure that could occur secondarily to certain drug exposures or after a hepatitis episode. For many years, the only treatment available was blood products. The first year survival was only 10%. The antithymocyte globulin (ATG) has improved the recovery rate to 25%. An allogeneic bone marrow transplantation provides a recovery of 60-80%; therefore, it is considered the treatment of choice.[7]

Autologous bone marrow transplantation (ABMT) rescues hematopoiesis after intensive chemotherapy and radiotherapy. This form of bone marrow rescue is available to a much greater number of patients than allogeneic or syngeneic transplantation. This modality does not have the problem of graft rejection or GVHD. The success of this procedure relies on the tumor dose response to assure a total tumor ablation, a proper storage, and a bone marrow free of disease. In case of advanced stage neuroblastoma, ABMT has improved the survival rate to 45%.[8] Those patients who received chemotherapy alone had a 5-year survival rate of 10%. Bone marrow transplantation is not indicated in malignancies in which chemotherapy alone provides a good cure rate. For example, children suffering from acute lymphoblastic leukemia may have an induction-remission of 90-95% and a 5-year survival greater than 50%. In children who relapse, the survival drops to approximately 15-20%. A 2-year survival using allogeneic transplantation for these patients have been reported from different institutions ranging from 40-60%.[6] One important unexplained phenomenon in transplanted ALL patients is the high post-transplant relapse rate, report incidence as great at 40%.

### Summary

Bone marrow transplantation provides a major therapeutic strategy for an increasing number of hematologic, immunologic, inherited, and metabolic disorders. It is a very tedious and expensive form of therapy. Medical centers will need a highly skilled team of laboratory and clinical specialists to provide this modality safely and effectively.

### References


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**–Ann Jillian**

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Those women, particularly those over 35, won't ask their doctor about a mammogram.

Yet that's what's required for breast cancer to be detected early. When the cure rate is 90%. And when there's a good chance it won't involve the loss of a breast.

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Life is just too wonderful to give up on. And, as I found out, you don't have to give up on any of it. Not work, not play, not even romance.

Oh, there is one thing, though.

You do have to give up being afraid to take care of yourself.

AMERICAN CANCER SOCIETY®

# The Tax Reform Act of 1986: A Thumbnail Sketch for Physicians

*Milford B. Hatcher, Jr.*

*Editorial Note: This article was solicited by us to acquaint our readers with the new tax law. Mr. Hatcher was chosen to write this paper because of his extensive background in tax law and his experience in representing individual physicians. In addition to his private practice, Mr. Hatcher is an adjunct professor of law, teaching Estate Planning at the Walter F. George School of Law, Mercer University, Macon.*

*Senator Richard L. Greene*
*MAG's General Counsel*

THE TAX REFORM ACT of 1986 has now been passed. Many of the provisions took effect on January 1, 1987, and thus currently apply. Among these provisions, which may have a special impact on physicians, are the following:

(1) *Tax Rates*. The tax rates have dropped. In 1987, the maximum rate for an individual is to be 38.5%, and the 1988 maximum rate is scheduled to decline further to 28%, assuming no further legislative changes. It should be emphasized that both the House and the Senate Democratic leadership have already raised the possibility of increasing the rates, at least for 1988 and later.

(2) *Base Broadeners*. Since the Tax Reform Act of 1986 is supposedly revenue neutral, the lower rates will be offset by so-called "base broadeners." These base broadeners are sweeping and include the following provisions which may especially have an adverse impact upon professionals.

(a) *Limits on Shelters*. The ability to shelter earned income from the practice of medicine has been drastically curtailed. As a general rule, starting with 1987, losses from "passive activities," specifically including limited partnerships and most "S" corporations, will be allowable as deductions only to the extent of income from passive activities. For pre-1987 shelters, there is a limited transition rule which permits 65% of the net losses to be deductible in 1987, 40% in 1988, 20% in 1989, 10% in 1990, and none thereafter. Even this transition rule, however, may not provide any relief in circumstances where the alternative minimum tax comes into play.

(b) *Deduction for Automobiles*. Deductions for automobiles have been cut back sharply in various respects. First, depreciation has been severely restricted; the maximum depreciation deduction, assuming 100% business use, is $2,560 for the first year, $4,100 for the second year, $2,450 for the third year, and $1,475 for each year thereafter. To put this in perspective, a $20,000 "luxury automobile" will take 11 years to depreciate fully. As if this lengthening of the depreciation schedule does not pose sufficient problems, the new law will not even permit an employee-physician to take advantage of this more limited deduction unless his or her depreciation and other automobile-related expenses, when combined with other "miscellaneous itemized deductions," exceed 2% of his or her adjusted gross income. For example, if a physician-employee would otherwise be entitled to deduct depreciation and other automobile-related expenses of $3,000, and if that physician-employee has an

Mr. Hatcher is senior partner in the tax firm of Hatcher, Smith, and Hawkins. Send reprint requests to him at P.O. Box 6495, Macon, GA 31208.

adjusted gross income of $100,000, only $1,000 of this depreciation and other automobile-related expenses will be allowable. The other $2,000, representing 2% of the $100,000 adjusted gross income, will be nondeductible. Finally, any interest paid on a debt used by a physician-employee to purchase an automobile will be personal interest, and will be only 65% deductible in 1987, 40% deductible in 1988, 20% deductible in 1989, 10% deductible in 1990, and non-deductible thereafter. Automobile reimbursement allowances and corporate ownership of automobiles may be means of minimizing the adverse impact of these new automobile provisions, but under any circumstances, the after-tax costs of an automobile will increase.

(c) *New Limits on Travel and Entertainment Expenses.* Further restrictions have been imposed on the deductibility of travel and entertainment expenses. Business meals must have a more direct relationship to the business. Generally, this means that business must be discussed during the meal or immediately before or after it. A "goodwill" meal will no longer be deductible. Even if it can be established under the new rules that the meal is in fact a "business meal," only 80% of the cost will be deductible. Similar rules apply to other entertainment expenses which are business-related. Next, investment seminars which do not have a close tie to the physician's practice will be non-deductible.

(d) *Loss of Investment Tax Credit.* The investment tax credit, which previously amounted to 6% to 10% of the cost of furniture, fixtures, equipment, and automobiles, was repealed retroactively to January 1, 1986.

(e) *Shift to Calendar Year.* Most medical practices will be required to use a calendar year for a taxable year starting in 1987. If a particular practice has previously been using a fiscal year, the switch must be made in 1987. For example, if a professional corporation previously used a July 1 through June 30 fiscal year, this professional corporation will be required to have a short fiscal year extending from July 1, 1987, through December 31, 1987. Thereafter, the professional corporation will be required to use the calendar year as a taxable year.

***"This article highlights some of the changes in the new tax law. The act itself covers almost 1,000 pages. To put the matter into perspective, the Internal Revenue Code of 1954 no longer exists . . . the full impact of this legislation is only now being gradually understood."***

(f) *Sweeping Qualified Plan Changes.* The Tax Reform Act of 1986 makes sweeping changes in the area of qualified retirement plans. Some of those changes go into effect in 1987. If a professional practice is maintaining an IRC §401(k)

cash or deferred profit sharing plan, the total deferrals by any employee for *calendar year* 1987 and for any calendar year thereafter will be limited to $7,000. If a physician-employee borrows any money from a qualified retirement plan in 1987 or later, it is likely that the interest will be nondeductible. If a professional practice is maintaining a defined benefit pension plan providing a normal retirement age before age 65, the benefits may be cut back materially; in fact, if the normal retirement age is 55 and the plan is otherwise being funded to the maximum extent that has been permitted in the past, an immediate termination of the plan may be in order. These are among the principal 1987 changes, but this list is by no means exclusive. Other largely technical changes will require the amendment of all plans by 1989. As a practical matter, however, the wisdom of maintaining any qualified retirement plans should be reevaluated in light of The Tax Reform Act of 1986. That is not to say that qualified retirement plans may not still be appropriate. However, if the reduction in the maximum rates does in fact go into effect in 1988, plans must be viewed as more of an employee benefit and less of a tax shelter.

The above changes made by The Tax Reform Act of 1986 only scratch the surface. The act itself covers almost 1,000 pages. To put the matter in perspective, the Internal Revenue Code of 1954 no longer exists. The Internal Revenue Code of 1986 now governs, and the full impact of this legislation is only now being gradually understood.

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You may find it surprising that up to 60% of all cancers can be prevented. By avoiding excessive exposure to sunlight, by not smoking cigarettes, by not overeating and by following a diet high in fiber and low in fat.

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## ERSONALS

*cond District*

**Jeff W. Byrd, M.D.,** has been elected Chief of Staff at Archbold Hospital in Thomasville. Laboratory Director at three hospitals, Dr. Byrd also serves on the Board of Governor's of the Georgia Association of Pathologists and is Secretary-Treasurer of the Georgia Association of Pathologists. He also serves on the Government Relations Commission of the College of American Pathologists, the Medicaid Physicians Advisory Board, and as the first president of Qualicare Physicians Association, Inc.

*Third District*

**Horatio Cabasares, M.D.,** a surgeon, has been named Chief of Staff at Perry Hospital where he has been on staff since 1981.

*Fifth District*

**Edgar Woody, M.D.,** internist from Atlanta, was honored at a recent meeting of the MAG Board of Directors with a Certificate of Appreciation and a framed portrait for his 32 years as Editor of the *Journal*. Dr. Woody will continue to serve in an advisory and consultative capacity as Editor Emeritus.

*Sixth District*

**W. Raymond Fannin, Jr., M.D.,** of Macon, recently received his certification in addictionology. Dr. Fannin is the clinical director for the Addiction Recovery Unit at Coliseum Psychiatric Hospital and is in private practice with the Psychiatric Center in Macon.

**Alan D. Kirth, M.D.,** a radiologist, has been elected Chief of Staff at the Medical Center of Central Georgia.

*Eighth District*

**Turner W. Rentz, M.D.,** a general practitioner and clinician at the Baker County Health Department, has retired after 31 years of service.

*Ninth District*

**John W. Garland, III, M.D.,** has been appointed Medical Director of the Psychiatric In-Patient Service at Northeast Georgia Medical Center in Gainesville. Dr. Garland also serves as Chief, Psychiatric Section at the same institution and as Chairman, Awards Committee, Georgia Psychiatric Association.

*Dr. Edgar Woody, an internist from Atlanta, was honored at the January meeting of the MAG Board of Directors with a Certificate of Appreciation and a framed portrait for his 32 years as Editor of the* Journal. *President John Watson (left) and Board Chairman Bill Collins look on. Dr. Woody will serve as Editor Emeritus of the* Journal, *in an advisory and consultative capacity. MAG is indeed grateful and indebted to Dr. Woody for his loyal work and service to the* Journal *and the Association.*

*Tenth District*

**Reggie Pilcher, M.D.,** a pediatrician, has begun work at Thomson Medical Specialists. He recently graduated from the Medical College of Georgia where he also completed his residency.

## DEATHS

**T. H. Moss, Sr., M.D.,** of Rome died last January at the age of 79. Dr. Moss practiced obstetrics and gynecology until 1980 when he retired. A member of several professional associations, Dr. Moss received his medical degree from the Medical College of Georgia. Survivors include three sons, a sister, 13 grandchildren, and seven great-grandchildren.

## ERRATUM

In "Table 5 — HIV Counseling and Testing Sites" on p. 22 of the January, 1987, *Journal*, the phone number listed for Muscogee County (Columbus) is incorrect. The correct number is 404-571-7236.

# *Physician Recognition Award Recipients*

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from October through December, 1986*

*The Award was established by the AMA House of Delegates in 1968 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored for Category I credit by organizations accredited for these activities.*

*We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:*

Robert W. Amler, Atlanta
John L. Anderson, Macon
Leon M. Armoreda, Douglas
William J. Atha, Rome
Charles E. Bagley, Alma
Istavan Balog, Brunswick
Richard A. Bardack, Marietta
John L. Barton, Athens
John H. Baskin, Atlanta
Isik D. Baydar, Cedartown
J. E. Becerra, Stone Mountain
Morton P. Berenson, Columbus
Arnold J. Berry, Atlanta
Ronald C. Bloodworth, Atlanta
Robert K. Bond, Ellijay
F. Iris Brazeal, Marietta
Harold J. Brody, Atlanta
Paul C. Broun, Americus
Ira P. Buchwald, Atlanta
William H. Cabaniss, Athens
Moo H. Cho, Columbus
Joe U. Choi, Stockbridge
Joseph Citron, Atlanta
Warren U. Clary, Savannah
Isabella S. Collins, Sea Island
Ronald N. Cook, Atlanta
Jerry L. Cooper, Decatur
Anthony M. Costrini, Savannah
George L. Cross, Atlanta
Ronald Daitch, Augusta
Gary M. Daniels, Marietta
Dave M. Davis, Atlanta
Keith J. Degi, Atlanta
Albert V. Dixon, Albany
Charles E. Drake, Savannah
Warren D. Elliott, Savannah
Henry M. Escue, Atlanta
Mary M. Faucher, Conyers
Thomas C. Fearneyhough, Albany
Nathan D. Feibelman, Macon
William R. Fisher, Atlanta
Darius Flinchum, Atlanta
Henry A. Foster, Griffin
Paul B. Francis, Decatur
Edgar Frank, Fort Benning
J. Howard Garten, Atlanta
Bijan Ghorashi, Atlanta
Ridley M. Glover, Dublin
Edwin H. Grant, Carrollton
William R. Grow, Valdosta
Margarita L. Guzman-Ferry, Dahlonega
Steven C. Hallberg, Austell
Jams F. Hammesfahr, Atlanta
Douglas P. Hein, Jesup
James D. Huber, Lithonia
Stephen C. Huber, Columbus
Jack R. Hunt, Columbus
Ray L. Johnson, Smyrna
George A. Johnston, Macon
Kenneth E. W. Jones, College Park
Mila Jorda-Montesclaros, Columbus
P. R. Kalathoor, Vidalia
Michael J. Kalson, Cumming
Harold P. Katner, Macon
Jeffrey H. Klopper, Smyrna
Somanath G. Kudchadker, Columbus
John D. Lane, LaGrange
Richard A. Langford, Dublin
Michael K. Levine, Atlanta
Fred A. Levin, Conyers
Rosa B. Licha-Baquero, Stone Mountain
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J. Salvador Martinez, Augusta
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James H. McNatt, Marietta
James A. Meadows, Savannah
Roger A. Meyer, Marietta
John F. Michaels, Warner Robins
Donald J. Mirate, Valdosta
Richard T. Mull, Martinez
Vytautas A. Pakalnis, Augusta
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Bhaskerrao M. Patel, Toccoa
Francis J. Peisel, Savannah
William C. Pfister, Tifton
Michaell J. Quinn, Martinez
Stephen N. Rando, Macon
Reubean A. Reynolds, Jonesboro
James W. Richardson, Newnan
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Jayshree H. Sampat, Albany
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Herbert D. Smith, Dublin
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EFFECTIVE MAINTENANCE THERAPY

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In two randomized, double-blind, and well-controlled clinical trials, ZANTAC 150 mg h.s. significantly superior to cimetidine 400 mg h.s. for maintenance therapy in healed duodenal ulcers.

Percent of patients with observed duodenal ulcer recurrence

| | | 0-4 months | 0-8 months | 0-12 months | No. patients |
|---|---|---|---|---|---|
| USA[1] | ranitidine 150 mg h.s. | 9% | 14%* | 16%† | 60 |
| | cimetidine 400 mg h.s. | 23% | 34% | 43% | 66 |
| UK, Ireland, Australia[2] | ranitidine 150 mg h.s. | 8%‡ | 14%‡ | 23%‡ | 243 |
| | cimetidine 400 mg h.s. | 21% | 34% | 37% | 241 |

*p=0.02
†p=0.01
‡p≤0.004
%=life-table estimates
All patients were permitted prn antacids for relief of pain.

These two trials used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comparison of other dosing regimens has not been studied.

The studied dosing regimens are not equivalent with respect to the degree and duration of acid suppression or suppression of nocturnal acid.

The superiority of ranitidine over cimetidine in these trials indicates that the dosing regimen currently recommended for cimetidine is less likely to be as successful in maintenance therapy.

Convenient once-a-night dose with a

low incidence of side effects[3]

Headache, sometimes severe, seems to be related to ranitidine administration. Other side effects have been reported; for a complete listing, see the **ADVERSE REACTIONS** section in the Brief Summary.

No significant interference with the hepatic cytochrome

P-450 enzyme system at recommended doses

ZANTAC 150 mg has no significant drug interactions with theophylline, phenytoin, or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH may be altered when ZANTAC or other medications that decrease gastric acidity are administered.

**Zantac® 150**

*ranitidine HCl/Glaxo 150 mg tablets*

One tablet at bedtime
for maintenance

See next page for references and
Brief Summary of Product Information.

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# Zantac® 150

ranitidine HCl/Glaxo 150 mg tablets

## *One tablet at bedtime for maintenance therapy in healed duodenal ulcer patients*


**References:**

1. Silvis SE, Griffin J, Hardin R, et al: Final report on the United States multicenter trial comparing ranitidine to cimetidine as maintenance therapy following healing of duodenal ulcer. *J Clin Gastroenterol* 1985;7(6):482-487.
2. Gough KR, Korman MG, Bardhan KD, et al: Ranitidine and cimetidine in prevention of duodenal ulcer relapse: A double-blind, randomised, multicentre, comparative trial. *Lancet* 1984;ii:659-662.
3. Data available on request, Glaxo Inc.


**ZANTAC® 150 Tablets (ranitidine hydrochloride)**
**ZANTAC® 300 Tablets (ranitidine hydrochloride)**

**BRIEF SUMMARY OF PRODUCT INFORMATION**

The following is a brief summary only. Before prescribing, see complete prescribing information in ZANTAC® product labeling.

**INDICATIONS AND USAGE:** ZANTAC® is indicated in:

1. Short-term treatment of **active duodenal ulcer.** Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within one or two weeks after starting therapy and is maintained throughout a six-week course of therapy.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

**CONTRAINDICATIONS:** ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

**PRECAUTIONS:** Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy.

Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSAGE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Although recommended doses of ZANTAC do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Lack of experience to date precludes recommending ZANTAC for use in children or pregnant patients. Since ZANTAC is secreted in human milk, caution should be exercised when administered to a nursing mother.

**ADVERSE REACTIONS:** Headache, sometimes severe, seems to be related to ZANTAC® administration. Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

There have been rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

**OVERDOSAGE:** Information concerning possible overdosage and its treatment appears in the full prescribing information.

**DOSAGE AND ADMINISTRATION: Active Duodenal Ulcer:** The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

**Maintenance Therapy:** The current recommended adult oral dosage is 150 mg at bedtime.

**Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome):** The current recommended adult oral dosage is 150 mg twice a day. In some patients it may be necessary to administer ZANTAC 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

**Benign Gastric Ulcer:** The current recommended adult oral dosage is 150 mg twice a day.

**GERD:** The current recommended adult oral dosage is 150 mg twice a day.

**Dosage Adjustment for Patients with Impaired Renal Function:** On the basis of experience with a group of subjects with severely impaired renal function treated with ZANTAC, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

**HOW SUPPLIED:** ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

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**Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.**


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# ADVERTISING INDEX


Ad Council ..... 156D

Air Force Reserve ..... 202

Allscripts ..... 156

American Cancer Society ..... 163, 180, 192, 212, 216

Americare ..... 177

Arthritis Foundation ..... 205

Atlanta Magnetic Imaging ..... 219

Ayerst Laboratories ..... 164B-D, 180A-D

Blue Cross/Blue Shield ..... 176

CNA Insurance Company ..... 204

Campbell Laboratories ..... 185

Data Plus Corporation ..... 155

Glaxo/Roche ..... 218A-D

Health Quip, Inc. ..... 213

Knoll Pharmaceutical ..... 172A-B, 210A-B, 211

Lilly, Eli & Company ..... 156

MAG Mutual Insurance Company ..... 154

Marion Laboratories, Inc. ..... 202A-B

Medical Association of Atlanta ..... 164

Ridgeview Adolescent Program ..... 175, 177

Roche Laboratories ..... 221, 222

Roerig ..... 156B-D

Upjohn Company ..... 164A

U.S. Army ..... 178

Weight Watchers of Greater Atlanta ..... 213

Woodridge Hospital ..... 201


# MANUSCRIPT INFORMATION

**MANUSCRIPTS** — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

**STYLE** — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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APRIL 1987

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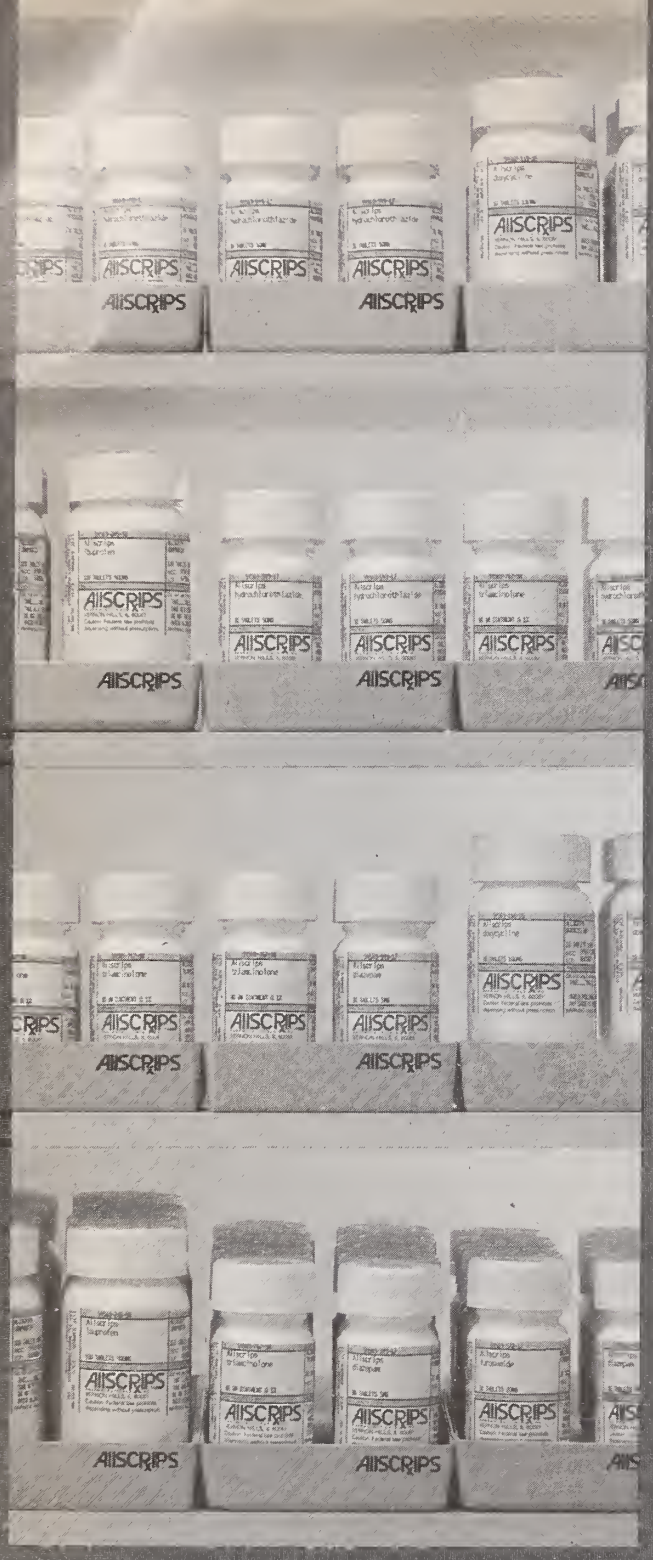


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| | CONSTIPATION | RESPIRATORY DEPRESSION | SEDATION | EMESIS | PHYSICAL DEPENDENCE |
|---|---|---|---|---|---|
| HYDROCODONE | | X | | | X |
| CODEINE | X | X | X | X | X |
| OXYCODONE | XX | XX | XX | XX | XX |

**Blank space indicates that no such activity has been reported.**

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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***The original hydrocodone analgesic.***

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**INDICATIONS AND USAGE:** For the relief of moderate to moderately severe pain.
**CONTRAINDICATIONS:** Hypersensitivity to acetaminophen or hydrocodone.
**WARNINGS:**
**Drug Abuse and Dependence:** VICODIN® is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
**Respiratory Depression:** At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
**Head Injury and Increased Intracranial Pressure:** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
**Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
**PRECAUTIONS:**
**Special Risk Patients:** VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
**Information For Patients:** VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
**Cough Reflex:** Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
**Drug Interactions:** The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
**Usage in Pregnancy:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
**Nonteratogenic Effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
**Labor and Delivery:** Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
**Nursing Mothers:** It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
**Pediatric Use:** Safety and effectiveness in children have not been established.
**ADVERSE REACTIONS:**
**Central Nervous System:** Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
**Gastrointestinal System:** Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
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**DOSAGE AND ADMINISTRATION:** Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982. 5685


1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med,* 141:293-300, 1981.


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# CONTENTS

VOLUME 76, NUMBER 4

## FEATURES

FOREIGN TRAVEL AND CME CREDITS
What Should Be Expected of Them? 235
By Evelyn Ward Gay

GEORGIA DOCTORS VISIT THE U.S.S.R. 241
By Evelyn Ward Gay

GEORGIA HEALTH NETWORK
More than an HMO 251
By S. William Clark, M.D.

THE HEALTH CARE BUSINESS 255
By Kenneth C. Henderson, M.D.

HEPATITIS B IN YOUR MEDICAL PRACTICE:
RISKS AND RECOMMENDATIONS 260
By Gary Schatz, Ph.D., Mark Kane, M.D.

## EDITORIAL

GEORGIA'S NEW TORT REFORM LAWS 231
By James A. Kaufmann, M.D.

## LEGAL

TORT REFORM IN 1987
A Significant Improvement 268
By Richard Greene

## HEART

A CASE OF "TORSADE de POINTES"
An Unusual Ventricular Arrhythmia 279
By Charles E. Drake, M.D.

## CANCER

ANTICIPATORY NAUSEA AND VOMITING 284
By Ann T. Foltz, R.N.

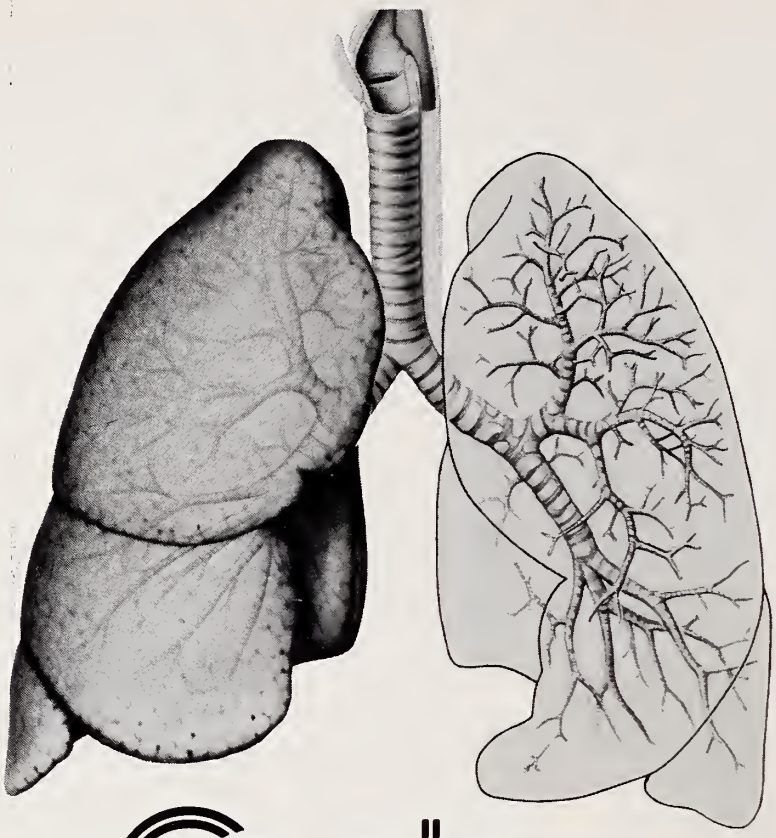
## DEPARTMENTS

PRESIDENT'S PAGE 229
EDITOR'S CORNER 230
CALENDAR 234
ASSOCIATION NEWS 287
AD INDEX/MANUSCRIPT INFORMATION 292

## COVER

The two articles by Mrs. Gay beginning on pages 235 and 241 are the focus of this month's issue. Photos by Chuck Rogers, of Atlanta.

# Consider the causative organisms...



# Ceclor®
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***Haemophilus influenzae, H influenzae, Streptococcus pneumoniae, Streptococcus pyogenes***
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*Note:* Ceclor® is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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**Summary. Consult the package literature for prescribing information.**

**Indications:** Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

**Contraindications:** Known allergy to cephalosporins.

**Warnings:** CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

**Precautions:**
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

**Adverse Reactions:** (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

**Abnormalities in laboratory results of uncertain etiology**
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
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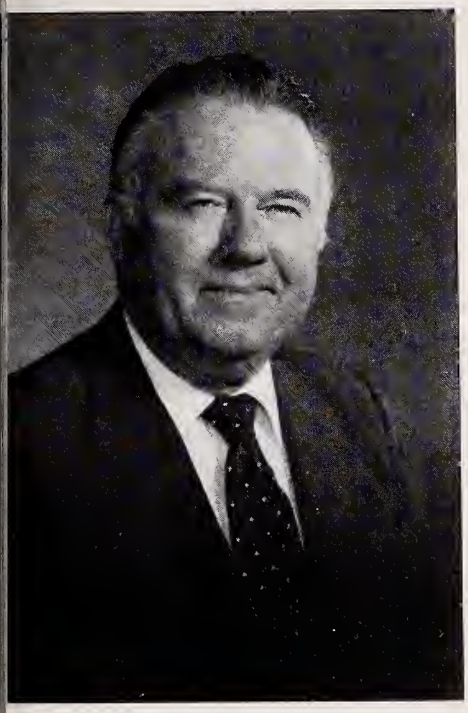
# A Closing Message



*John D. Watson, Jr., M.D.*

It is always hard to write a final letter. There are so many people I would like to recognize, so much I would like to say — to commend the MAG staff for their actions and support, to thank the members of the Executive Committee and the multiple Committee Chairmen and their Committee members for their excellent contributions. Yet, there is another message which I would like to convey at this time, a message that in my mind is so basic and vital if we are to survive as that Great Learned Profession.

There can be little doubt as to what we need to do: to be available, to be accessible, and to place patient need first and finances second. We are trying now to address the indigent issue, and only we can solve it with some legislative relief. I would like to use this following statement of purpose as my closing message about how I feel about our Great Profession and our Charge:

*"Take my hand —*

*Doctor, tell me I'll be all right! Tell me I'll see my children finish school. Or, tell me I'll see my first grandchild. Or, tell me that my Mom or Dad will come through this illness O.K. Or, tell me that my Baby will be all right — I know it hasn't moved in a few days, but!! Or, tell me that what I have is curable — there is so much I need to know!*

*I know you have such marvelous drugs, such marvelous technology, such amazing new techniques and other experts to call on. I know you have spent many years developing your skill. Yet, I know you cannot perform miracles either.*

*If you cannot do these things, if you cannot tell me what I want to hear, then do what is best for me and my family. For you know me, you know my family. You know that I have placed my life, my trust, and my confidence in your hands. And when that time comes when you have exhausted your resources, take my hand. Let me lean on your strength, your touch, your understanding. Take my hand — for you are MY Doctor."*

To say it has been a pleasure to be your President is the understatement of the year. We have many challenges facing us, and we can overcome the majority of them with cooperative and informed participation by all of us. We dare not fail — the consequences are too formidable.

Thank you for allowing me to serve in this most distinguished position. It has indeed been an honor and a pleasure.

Sincerely,

John D. Watson Jr. M.D.

# On Forming Up Into Teams

***"We must remember that training hard and making elaborate plans are but the preparations for the main show. . . . Let not all of this getting ready, all the trappings of the meeting, lull us into the illusion that we are making progress when really we have simply been shuffling paper."***

WE ARE GOING to do it again, this annual coming together of our federation, as we have for so many years now. This April 1987 will mark the 133rd time that we have made this annual pilgrimage to one city or another in our continuing effort to represent the physicians of this State in an "organized" manner. We will, as in the past, study and debate, write and revise reports. Finally, we will make decisions that in one way or another, for good or ill, will affect the lives of all of us who practice medicine within the bounds of this once English settlement and which will impact the lives of those citizens of this State who entrust their health care to us. The issues which we find for debate will, in some respects, be far different from those of earlier years. The conversation will range not about the quality of the horse that pulls the buggy, for that seemed to be of paramount importance to my father as he recounted the nighttime rides in a buggy with his own father through the dirt roads of Alabama on night obstetrical calls, but rather will concern the intricacies of freestanding out-patient surgical units, third party payment methodology, length of stay issues, and quality of care concerns.

PETRONIUS ARBITER was concerned about the matter of organizations and in particular about "reorganizing." He saw the hazard of meetings for meetings' sake and the need to focus on true, genuine, and accomplishable decisions. Petronius was the "Arbiter Elegantiae" at the Court of Nero. He was perhaps best known as the author of "The Satyricon," considered perhaps to be one of the first examples of the novel form and producing in that writing a clear and quite realistic picture of the luxuries, vices, and social matters of the Imperial Age of ancient Rome. He was talking about organizing, reassessing gains and accomplishments, and making plans for future action when he commented, "We trained hard . . . but it seemed that every time that we were beginning to form up into teams, we would be reorganized. I was to learn later in life that we tend to meet any new situation by reorganizing; and a wonderful method it can be for creating illusion of progress while producing confusion, inefficiency, and demoralization."

I THOUGHT ABOUT that observation as I looked back over the last few years of these annual sessions and thought about the coming of this one. We do indeed "train hard" for this affair. We meet and discuss and write resolutions. We arrange hotels and meeting rooms with microphones and modern means of recording our deliberations. And then we gather fo the final onslaught upon the myriad of problems that present themselves We produce thousands of pages of written communication. We flood th mails with information to our "delegates." And for what, this annual frenzy to meet and to "reorganize"?

IT IS, OF COURSE, to keep the organization, the Medical Associatio of Georgia, continuing as it has through the years a special place where physicians can gather and in reasoned debate look at those matter pertaining to the practice of medicin as they impact the health of our people. A place also where we can look at our own lives and study the completeness to which they are bein lived. We must do so with calmness with reason, with knowledge of that about which we debate. We must do so with a view toward producing a workable decision. We must remember that training hard and making elaborate plans are but the preparations for the main show. We must remember the old Roman, Petronius, and not let all of this getting ready, all the trappings of th meeting, lull us into the illusion that we are making progress when really we have simply been shuffling paper

And then when the battle is done, when the debates are over, and the reports written, let us all attend the President's Reception and with a sense of satisfaction remember the good advice of Sir Thomas More:

"Let thy joys alone be remembered now,
Let thy sorrows go sleep awhile."

*Charles R. Underwood, M.D.*
*Interim Editor*

*Dr. James A. Kaufmann (L) speaks to the Georgia House of Representatives as its Speaker, Tom Murphy, looks on. The two parts of the tort reform package passed by the 1987 Georgia General Assembly are (1) The Medical Malpractice Reform Act of 1987 and (2) The Tort Reform Act of 1987. Gov. Joe Frank Harris has made it clear that he will sign the two tort reform bills, which will take effect July 1.*

# *Georgia's New Tort Reform Laws*

## *A Long Step in the Right Direction*

HYSICIANS THROUGHOUT GEORGIA wondering what effect the tort orm package — passed by the 87 General Assembly — will have the professional liability crisis in orgia. I have been asked by the tor of this *Journal* to give a aningful interpretation of these w laws and how they will affect mbers of the Medical Association Georgia.

### Significant Changes Under the New Laws

Juries will be told of other sources l amounts of compensation intiffs have received and about future payments to which they are entitled. Also, the plaintiff now has the right to tell the jury what he has paid, if anything, to receive these compensations. At present, it is against Georgia law to tell juries about insurance, disability, or compensation payments that the plaintiff has received or is entitled to in the future. I think this will have a profound effect on the size of jury awards and a secondary effect in lowering the amount of pre-trial settlements.

Another part of the package passed by the 1987 General Assembly requires an affidavit from an expert competent to testify setting forth a negligent act and the factual basis for such claim. This must accompany every lawsuit filed for professional malpractice. As a result of this, I believe many frivolous lawsuits will be prevented, particularly where multiple professional defendants are sued in the same case, i.e., those actions where the "immediate world" is sued.

THE STATUTE of limitation for minors was also changed by Georgia's lawmakers and will, in the long term, be very helpful. And, the statute of repose will also help in

***"Georgia's Tort Reform is excellent on the whole, a unique law in that it encourages charity work. The other provisions are simply outstanding, especially the collateral source rule and the statute of limitations for minors."***

DONALD J. FAGER
PRESIDENT
PHYSICIAN INSURERS ASSOCIATION OF AMERICA

preventing cases that are years old and difficult to defend. When the child reaches the age of 5, he or she will have a 2-year statute of limitation and a 5-year statute of repose. Under the previous law, the same statute of limitation and statute of repose did not begin until the child's 18th birthday.

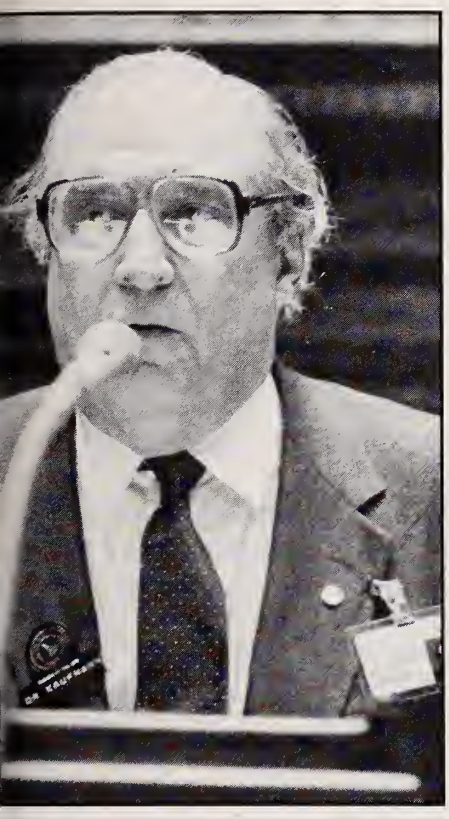
INTERESTINGLY, another section of the new laws that should have been noncontroversial created a great deal of controversy. I are referring to the extension of the Good Samaritan Act. Under the new statute, a physician who voluntarily and without the expectation or receipt of compensation who provides professional services for and at the request of a hospital, public school, nonprofit organization, or an agency of the state or local government shall be liable only for gross negligence or willful misconduct. In my opinion, this provision will increase the amount of charitable care and other types of volunteer services given by physicians. Although this gives increased protection, it should be noted this is not total immunity, as juries often find gross negligence when a person has been severely injured by an act of a physician.

In addition, officers, trustees, directors, and members of nonprofit organizations (such as MAG and its Auxiliary, county medical societies, Boy Scouts, Special Olympics, etc.) are granted immunity as long as they are acting in good faith. (I know of a recent lawsuit where the wife of a prominent Atlanta physician was sued because she was serving on the board of a charitable organization.)

*As Lt. Gov. Zell Miller listens, Dr. James A. Kaufmann (R) addresses the Georgia Senate regarding MAG's medical activities at the Capitol.*

The new legislation also provides for the apportionment of damages among the defendants if the plaintiff is to some degree at fault. The previous doctrine of joint and several liability often required a "deep pocket" defendant to pay an entire verdict even if he were only one percent at fault. In most medical malpractice cases involving a physician and a hospital, the award paid equally by both. The new law remains the same, which generally is to the advantage of the physician unless the jury first finds that the plaintiff was also negligent.

THIS ASPECT of the new laws may also change the way negligence is argued to juries. This may lead to disputes between the various defendants as to who was most at fault and could make these cases more difficult to defend. However, this statute is a totally new concept that has never been tried before.



er reviewing this language, many l it may be favorable to the ysician in certain cases and be a plus, as it relates to joint and eral action between different ysicians, the physician and the pital, and even the physician, pital, and patient/plaintiff.

HE ABILITY of the judge to modify award is expanded under the new . With the agreement of the ties, the judge may decrease or rease an award that he feels arly excessive or insufficient. wever, if the parties to the lawsuit not agree, the judge can order a v trial considering only the ount of damages. I am hopeful t this will have a positive effect in trolling runaway jury verdicts. n the past, physicians have dom been assessed with punitive nages. However, recently there e been several large verdicts inst physicians for punitive nages. Under the new statutes, if ry decides to award punitive nages, then a separate proceeding l be held to determine the size of award, and the award shall be in case greater than $250,000 except for products liability and cases where there was a specific intent to cause harm.

In addition to the specific relief that this law gives, I am delighted that the major step in establishing the precedent of caps on awards in Georgia has been bridged. I am also delighted that the figure of $250,000 as a cap was determined rather than significantly higher amounts as some other states have adopted (i.e., a $1,000,000) that create a precedence for ridiculously high jury awards. These Georgia features will assist, if necessary for the public good, to extend this cap to pain and suffering awards at realistic levels.

***"I predict that the filing of medical malpractice claims will be cut in half within 12 to 24 months of the effective date of the Act because of the requirement of a prefiling affidavit."***

W. PITTS CARR
PLAINTIFF'S ATTORNEY, ATLANTA
CHAIRMAN, GOVERNOR'S ADVISORY COUNCIL ON TORT REFORM

Another very important statute is the act to give immunity to medical students in Georgia hospitals when working under the direction of a faculty member, except for acts of willful and wanton misconduct.

Assuming the Governor signs these bills into law, as he undoubtedly will, most provisions become effective July 1, 1987.

IN AN OVERVIEW of Georgia's new tort reform laws, I caution that it will probably be 2 to 3 years before the major benefits of these bills will be apparent. Despite the fact that every precaution was taken to carefully write these bills to withstand constitutional challenge, it is highly probable some trial lawyers will try to challenge them.

I believe these new laws will have a substantially beneficial affect on the professional liability climate in Georgia. However, it must be emphasized that there are many other aspects of medical liability. Training of physicians and their staffs in loss prevention measures is an aspect that should never be overlooked. In addition, there are many other things that physicians and their staffs can do that would prevent litigation without increasing medical costs. Most importantly, they should learn and be ever cognizant of requirements of the law that must be followed in this litigious society in order to stay out of court and be able to spend that time taking good care of patients.

*James A. Kaufmann, M.D.*
*Chairman, Council on Legislation*
*Chairman, Medical-Legal Committee*

# CALENDAR

## APRIL

25-26 — *Atlanta:* **The Cardiac Patient.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

27 — *Atlanta:* **Perspectives of Asthma in Late Childhood and Adolescence.** Category 1 credit. Contact the American Lung Association of Atlanta, 723 Piedmont Ave., Atlanta 30365. PH:404/872-9653.

27-May 2 — *Augusta:* **22nd Annual Family Practice Symposium.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

## MAY

3-7 — *Sea Island:* **Georgia Society of Ophthalmology Annual Meeting.** Category 1 credit. Contact Ray Williams, Exec. Dir., GOS, 938 Peachtree St., Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

7-9 — *Atlanta:* **Human Papillomaviral Infection and Lower Genital Tract Neoplasia: An Advanced Course for Pathologists and Clinicians.** Category 1 credit. Contact Mary Claire Jones, Dir. of Educational Services, St. Joseph's Hospital of Atlanta, 1100 Johnson Ferry Rd., Ste. 510, Atlanta 30342. PH:404/851-7025.

9-10 — *Augusta:* **Postgraduate Pathology Symposium.** Category 1 and AAFP prescribed credit. Contact William C. Allsbrook, Jr., MD, Dept. of Path., MCG, Augusta 30912. PH:404/828-3967.

14-17 — *Savannah:* **Patient Monitoring in Anesthesia and Critical Care.** Co-sponsored by the Georgia Society of Anesthesiologists. Category 1 credit. Contact Amer. Acad. of Anesthesia Assoc., P.O. Box 77253, Atlanta 30357.

16 — *Savannah:* **Otology in Primary Care.** Category 1 credit. Contact Jean Humphries, Memorial Medical Center, P.O. Box 23089, Savannah 31403. PH:912/356-8302.

22-25 — *Sea Island:* **Georgia Neurosurgical Society Annual Meeting.** Category 1 credit. Contact J. Paul Ferguson, M.D., Secy. Treas., GNS, 1825 Martha Berry Blvd., Rome 30161. PH:404/291-0545.

27-29 — *Atlanta:* **Advances in the Pathophysiology, Diagnosis, and Treatment of Cardiovascular Diseases.** Category 1 credit. Contact Dept. of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/727-5695.

28-29 — *Callaway Gardens:* **15th Annual Perinatal Medicine Conference.** Category 1 credit. Contact Div. of Perinatology, The Medical Ctr., P. O. Box 951, Columbus 31994. PH:404/571-1000.

## JUNE

7-11 — *Sea Island:* **Twelfth Annual Symposium on Lung Disease.** Category 1 credit. Contact American Lung Association of Georgia, 2452 Spring Rd., Smyrna 30080. PH:404/434-5864.

8-10 — *McCormick, SC:* **Seizure Disorders in Children.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

12-14 — *Sea Island:* **Georgia Society of Dermatology Annual Meeting.** Category 1 credit. Contact Gerald Chotiner, M.D., Secy.-Treas., Society of Dermatology, 3250 Howell Mill Rd., NW, Ste. 201, Atlanta 30327. PH:404/352-1730.

15-18 — *Kiawah Island, SC:* **18th Annual Internal Medicine Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

18-21 — *Sea Island:* **Georgia Ch ter of the American Academy Pediatrics Spring Meeting.** C gory 1 credit. Contact William Mankin, Exec. Secy., Ga. Chap AAP, 4059 Land O'Lakes Drive, lanta 30342. PH:404/237-3922.

25-27 — *Hilton Head Island,* **Daily Anesthetic Challenges 1987.** Category 1 and AAFP p scribed credit. Contact Div. of C Ed., MCG, Augusta 30912. PH:4 828-3967.

29-July 2 — *Kiawah Island,* **Hematology-Oncology Symp ium.** Category 1 and AAFP p scribed credit. Contact Div. of C Ed., MCG, Augusta 30912. PH:4 828-3967.

## JULY

9-11 — *Kiawah Island, SC:* **7th nual Clinical Obstetrics.** Categ 1 and AAFP prescribed credit. C tact Div. of Cont. Ed., MCG, Augu 30912. PH:404/828-3967.

10-11 — *Savannah:* **SMA's Clini Postgraduate Conference.** Ca gory 1 credit. Contact Jeanette Sto SMA, P. O. Box 190088, Birmi ham, AL 35219-0088. PH:205/9 1840.

13-16 — *Kiawah Island, SC:* **Clini Cardiology.** Category 1 and AA prescribed credit. Contact Div. Cont. Ed., MCG, Augusta 309 PH:404/828-3967.

22-26 — *Kiawah Island, SC:* **1 Annual Critical Care Medicine.** C egory 1 and AAFP prescribed cre Contact Div. of Cont. Ed., MCG, gusta 30912. PH:404/828-3967.

27-29 — *Kiawah Island, SC:* **1 Annual Pediatric Update 1987.** C egory 1 and AAFP prescribed cre Contact Div. of Cont. Ed., MCG, gusta 30912. PH:404/828-3967.

27-29 — *Atlanta:* **American Hospi Association.** Contact AHA Office, S. State St., Salt Lake City, 84111.

# To show you how many hypertensives stayed on

# INDERAL® LA
(PROPRANOLOL HCl)

# after a major nationwide trial...

...we had
to find
just the
right room.

# 60,073 patients (90%) who started on INDERAL® LA stayed on INDERAL LA.[1*]

## Surprising? Not really.

Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.
A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients[2] revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol—which shows how well-tolerated once-daily INDERAL LA can be.

## Sole therapy or concomitant therapy? Fifty-nine percent of the time, INDERAL LA stood on its own.

The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were controlled merely with the addition of a diuretic to INDERAL LA.

## For the noncompliant patients in your practice, INDERAL LA may well be the answer.

Almost 20,000 of the patients in the nationwide compliance trial were identified as having been noncompliant with their previous antihypertensive therapy. Their physicians reported that 88% showed improved compliance when placed on once-daily INDERAL LA.

# Control, comfort, and compliance

ONCE-DAILY
**INDERAL® LA**
(PROPRANOLOL HCl)
LONG ACTING CAPSULES

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

# The one you know best keeps looking better

Please see next page for brief summary of prescribing information.

# The one you know best keeps looking better

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

**INDERAL® LA** brand of propranolol hydrochloride **(Long Acting Capsules)**

**DESCRIPTION.** Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules

**CLINICAL PHARMACOLOGY.** INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

**INDICATIONS AND USAGE. Hypertension:** INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

**Angina Pectoris Due to Coronary Atherosclerosis:** INDERAL LA is indicated for the long-term management of patients with angina pectoris.

**Migraine:** INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

**Hypertrophic Subaortic Stenosis:** INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

**CONTRAINDICATIONS.** INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

**WARNINGS.** CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

**Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)**—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

**PRECAUTIONS.** *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

*Clinical Laboratory Tests:* Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

*Carcinogenesis, Mutagenesis, Impairment of Fertility:* Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

*Pregnancy:* Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

*Nursing Mothers:* INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

*Pediatric Use:* Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS.** Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

*Cardiovascular:* bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

*Central Nervous System:* lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

*Gastrointestinal:* nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

*Allergic:* pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

*Respiratory:* bronchospasm.

*Hematologic:* agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

*Auto-Immune:* In extremely rare instances, systemic lupus erythematosus has been reported.

*Miscellaneous:* alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

**DOSAGE AND ADMINISTRATION.** INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

**REFERENCES:**


1. INDERAL LA National Compliance Evaluation Program. Data on file. Ayerst Laboratories
2. Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985; 145:1321-1323.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# Foreign Travel and CME Credits

## What Should be Expected of Them?

***by: Evelyn Ward Gay***

*(EDITOR'S NOTE: The MAG, in cooperation with the Medical Association of Atlanta, offers Georgia physicians the opportunity for foreign travel through INTRAV, Inc., of St. Louis. Physicians and their spouses returning from INTRAV trips have judged them extremely enjoyable and well planned.*

*Each trip includes an optional continuing medical education seminar. We wanted to find out what doctors thought of these CME programs which usually offer lectures by American and foreign physicians, tours of foreign medical facilities, and AMA Category 1 credit.*

*Mrs. Gay has interviewed a number of physicians and asked them what they thought of this vacation-education. Here are her findings.)*

In recent years, some concern has surfaced periodically among a few Medical Association of Georgia (MAG) members in regard to the state organization's sponsorship of Continuing Medical Education (CME) seminars offered in conjunction with travel agents' tours of foreign countries. These concerns have followed complaints that some of the seminars as planned by travel agents "do not meet our essentials."

At the suggestion of one physician that some of the answers to such problems might be found by going to the grass roots for accurate information, this writer has joined several such journeys to Europe offered by one of these tour companies. Results of interviews with participants on these occasions have been interesting, surprising, and most enlightening.

**Physicians' Comments**

The first, a 2-week trip called "The Dutch Waterways Adventure," promised 6 days and nights aboard the *Amicitia*, a specially-designed boat which cruised the waterways of The Netherlands, with conducted excursions into Amsterdam and the smaller towns along the shoreline, 3 days in Paris and the surrounding areas of France, and a final 3-day period in Montreux and other points in Switzerland.

Medical seminars for those physicians who wished to attend had been arranged. A check with the planner revealed that many of the physicians who would take the tour had signed up for these seminars while others had not done so. Varying reasons for their choices were given later by several physicians from both groups.

These physicians had come from many parts of the United States and represented the major medical centers in Connecticut and Massachusetts, and others in Michigan, Indiana, Ohio, Virginia, West Virginia, Tennessee, Alabama, Georgia, Florida, and Texas. Many of those who *did* attend the medical sessions in Paris and Montreux were repeaters who had found the scientific papers presented on other such tours to be informative and worthwhile. Many of these physicians were generalists. Those who did *not* attend the seminars were usually (but not always) specialists whose interest lay outside the subjects to be covered.

At no time during the 2 weeks was there heard a note of disappointment from any of the physicians concern-

A physician from McAllen, Texas, accompanied by his wife and two of their grown children, said that he had refrained from attending the seminars in Paris simply because "as an orthopedic surgeon, I naturally have little interest in ophthalmology."

An Iranian physician from Monticello, Indiana, who had lived in the United States for 30 years, was traveling alone on his 19th trip abroad. A family practitioner who formerly had specialized in obstetrics and gynecology, he stated that he enjoyed the medical seminars and always learned much from each. Agreeing with another physician, he held the opinion that no knowledge is ever wasted, even if it is not in the participant's regular field of practice.

Mrs. Gay is a freelance writer in Atlanta and author of the book *The Medical Profession in Georgia – 1733-1983*

*ON AN OVERCAST DAY in Deventer, Holland, Dr. Francis M. Gay, of Moultrie, Ga., discovered the statue of Dr. Albert Schweitzer, who had worshipped at the ancient church, Grote Kerk, a few blocks away during a residence in that city.*

Dr. Generoso B. Duremdes, a general surgeon, and his wife, Dr. Janelle B. Duremdes, a pediatrician, from Princeton, West Virginia, were accompanied by their son, Gene, who would enter medical school in the fall. Both doctors expressed approval of the subject matter contained in the seminars.

Three physicians from Georgia made this trip. Two were repeaters, but only one of the three chose to take part in the medical sessions. Dr. Francis M. Gay, a family practitioner from Moultrie (no relation to the writer), who with his wife had taken many tours of this type, found the medical programs to be to his satisfaction. ing the way the tour had been planned and promises kept. Most of the comments from the group of about 100 travelers (some of whom were not physicians) were that every detail to make them happy had been taken care of by the travel director who was with them throughout the 2 weeks' journey.

A cardiologist from Bedford, Mass., and his wife were the parents of eight children (one of them born in Georgia while he was stationed there with the Army). They, like several others, were taking their first 2-week vacation since he had begun his practice. As one of those who attended the seminars, he could find nothing uncomplimentary to say about the quality of the program.

Dr. Irving M. Levine, a psychiatrist-neurologist from Newton Center, Mass., was traveling with his wife, Helen, who worked for a group of obstetricians in Boston. He was most enthusiastic in discussing his experiences in Paris following a medical program which included a visit to one of that city's largest hospitals. Finding much of interest in the unusual design of the French structure, he was especially fascinated by the fact that each specialty was housed in a separate wing and the facilities of each were completely independent of the others.

*THE TRAVELERS SPOTTED an umbrella with a familiar advertisement on the terrace of the Seilerhaus Restaurant in the small traffic-free town of Zermatt, Switzerland, before boarding the cogwheel train for a ride to the top of the Gornergrat for a view of the Matterhorn. This restaurant had been recommended to future travelers by Edward Whymper, first conqueror of the Matterhorn, in 1864.*

Several of the physicians stated that they were deeply impressed and appreciative of the various services performed by the company. It was evident that a great deal of advance planning had gone into scheduling the many educational events offered, including tours of the well-known museums in Holland and France, with English-speaking guides, stops in cheese, pottery, and diamond factories, time to explore the small picturesque villages in Holland and shopping in Paris, a thrilling ride at more than 165 miles an hour on a train across the French countryside to Switzerland, a climb on a cogwheel train to the top of the Gornergrat for a spectacular view of the Matterhorn, a sunset dinner-cruise on the River Seine (at which some of us celebrated our wedding anniversaries), a tour of a war museum, and a dinner and dance at a castle in Arnhem, Holland, another dinner with entertainment at a chalet high in the Swiss Alps, and much more.

A 2-week trip some months later to the British Isles, planned by the same agency, produced much the same opinions during several interviews with participants.

On this journey, there were no other physicians currently living and practicing in Georgia, but there were

*IN PARIS, Dr. and Mrs. George P. Ezzard (right), of Lawrenceville, with their daughters, Margaret and Carolyn, enjoyed a sunset/dinner-cruise on the River Seine.*

*UPON ARRIVING at the Dunloe Castle Inn near Killarney, Ireland, Dr. Brit Gay, of Emory University, discovered that Dr. Ben Franklin, a fellow traveler from California, was a graduate of the Emory University School of Medicine.*

several practicing in other parts of the country who were graduates of Georgia medical schools.

The British Isles tour included visits to many well-known attractions in Ireland, Scotland, and England, as well as medical seminars and site visits in several locations. The physicians were especially interested in learning about the two levels of health care available to the people in Dublin, Ireland, and the poor facilities in which the physicians had to work, as compared to the more modern ones in England and Scotland.

A more recent tour of the Soviet Union provided the same type of opportunity to ask questions and record answers from many of the travelers about their views of foreign travel as a means of gaining CME credits. Again, the participants were most complimentary of the plans made and carried out by the travel agency. *(Ed. Note: See Mrs. Gay's article, "Georgia Doctors Visit the U.S.S.R.," elsewhere in this issue.)*

All of the activities on these tours had been scheduled very carefully so that the physicians could participate in many types of entertainment without having to miss any of the medical seminars which they wished to attend.

**Criteria for CME Programs**

A spokeswoman in St. Louis, who was in charge of the Continuing Medical Education programs for the tours, gave me some information on how the subjects and speakers for these events are chosen.

First, she said, medical organizations over the country are contacted to find out if a certain format which is being planned allows their members to participate. The sales division then works with the agency's operations department to fit educational seminars into travel plans. She added that "medical contacts are maintained from beginning to end."

In order to assure that the seminars will conform to the requirements of the AMA's Continuing Medical Education programs for their Physician's Recognition Award, an advisory board made up of physicians from various academic backgrounds is chosen. These physicians do the selecting of topics to be covered and suggest names of physicians who practice in the localities to be visited. The coordinator at the agency then works with the physicians in those countries to try to cover as many diverse subjects as possible. Every physician who has made reservations for the tour is sent in advance a description of the seminar topics and hospitals or clinics to be visited, as well as the names of speakers selected, in order that he/she might check beforehand the credentials of the speakers. A physician may sign up for the program or decline to do so.

After each tour which includes medical programs, an evaluation follow-up is requested from those who attended the sessions, said the agency representative, and the results are tabulated and furnished to each person who had signed up for the program. The comments of the respondents are used to plan and carry out similar events in the future.

A few of the physicians interviewed for this article expressed the opinion that the scientific papers presented on such tours have been much more valuable to them than some of the programs sponsored by medical schools, hospitals, or medical organizations, which often choose such recreational areas as a ski resort in Colorado, or a beach location in the Bahamas, for their programs. The latter, they claim, include at times such subjects as how to set up a medical practice, or other topics non-essential to the treatment of patients, and therefore are less attractive to them as a means of earning CME credits.

Several physicians brought up the fact that an additional pleasure to be derived from foreign travel of this type, aside from the medical papers presented, is the opportunity to meet with people from other countries and discuss with them their systems of health care and the extent of their governments' intervention into the practice of medicine. This thought was echoed by other physicians who had taken previous excursions to other parts of the world. Said one of them: "I enjoy the interchange of ideas among physicians from all over the globe. My expectations have been kept to a minimum. I then can make my own determination of the value of any trip. I never set out in search of Brownie points."

Sometimes, too, it was pointed out, there are non-physician travelers along in a group who contribute unexpected information that is both useful and interesting. On the Dutch Waterways Adventure, a retired architect from Houston, Texas, who had spent many years designing hospitals, stopped often to discuss his work while looking over some of the centuries-old structures which are still standing in the countries visited.

The wives of several of the physicians mentioned other advantages of these excursions. Chief among them was the expertise with which the planners handle all of the large and small details that must be taken care of for a trip, such as baggage transfers, reservations in the best hotels, and admittance into museums and other attractions which is often difficult for people traveling on their own. Others called attention to the group rates available, and the camaraderie which inevitably comes when people with like interests get together. Many lasting friendships are made on these tours.

Additionally, if there was any inconvenience caused by what is sometimes referred to by some people as "regimentation" on these tours, the wives found little evidence of it. A traveler could be as free as he or she wished to be, as long as scheduled flights in and out of countries were met, and was not required to attend any of the attractions planned. The possibility of feeling "controlled" was more than offset for most people by the obvious fact that a travel agency's badge opened many doors to travelers who were unfamiliar with the local language and the established mores, to say nothing of the ease with which it allowed them to get through customs or to pass a border patrol into a strange land.

There was another important side effect as well. Commented one thoughtful spouse: "The person who does not have a feeling of sheer joy while watching a doctor shed his pressures for a short while as he relaxes or takes a few steps on a dance floor in a secluded castle, far away from the usual cares of his life, is hopelessly devoid of any sensitivity to the burdens of others."

The shared beliefs of the men and women interviewed can be summed up in the following points:

1) While travel agency tours offering medical seminars and visits to foreign hospitals and clinics certainly are enjoyable and profitable in many ways, most physicians would not rely entirely upon the limited sessions available for CME credits. More complete educational programs are available on a regular basis for this specific purpose through medical schools, specialty societies, and hospital meetings.

2) However appropriate or inappropriate the seminars may be to various individuals, there is much more to be gained on a visit to foreign countries than the information contained in the scientific lectures alone.

3) Lastly, a majority of physicians realize that a travel agency's planned program cannot be submitted to all sponsoring groups for prior approval and input. It would be impossible to please everyone. Time and the many details involved do not permit such a wide concession. As in any large undertaking, a committee, which has been selected judiciously from the best representatives of the prospective participants, must be charged with making the final decisions. It is then left to the individual traveler to choose the tour that best suits his/her requirements. ■

*BLEINHAM CASTLE, the boyhood home of Sir Winston Churchill, was a favorite with most of the visitors to England.*

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# Georgia Doctors Visit The U.S.S.R.

***by: Evelyn Ward Gay***

"Every American should have such an experience."

That statement, made by one of the participants, adequately expressed the feelings of the five Georgia physicians and their wives who recently joined a group of 80 people from all sections of the United States for a two-week tour of the Soviet Union.

Called "The Journey of the Czars" by INTRAV, the organization which planned a part of the visit especially for physicians, the tour took the travelers first via *Aer Lingus* to Shannon, Ireland. Several hours later, the Soviet Airline's *Aeroflot* flew them on to *Sheremetyevo,* Moscow's international airport.

From that point, the tour group would be guided by *Intourist,* the official government travel agency for the U.S.S.R., which oversees the whereabouts of foreigners in the world's largest country, an area covering 8,649,500 square miles, over 1/7 of the world's total land mass.

Large, comfortable buses transported the visitors from the airport to their hotel on the opposite side of the city. Along the route they were immediately struck by the architecturally beautiful old buildings that lined the streets, and the number of massive highrise apartment buildings which house most of the inhabitants of this ancient capital city of 9 million people, whose history dates back to the year 1147. Also impressive were the city's many parks, gardens and shady boulevards which dot the landscape, taking up more than 30 percent of the city's area. Noticeable too was the absence of billboards defacing the scenery.

After a tour past some of the metropolis' 80 institutions of higher learning, over 4,000 public libraries, 100 museums, 30 professional theaters and concert halls, and a dozen or more sports arenas, and listening to a capsule commentary on the city's major industries, the guests reached their headquarters for a 3-day stay—the Cosmos Hotel on Peace Avenue.

*The American travelers were welcomed to Moscow at an informal dinner at the Cosmos Hotel. Shown here are (rear) Dr. and Mrs. William D. Logan, of Atlanta, and Dr. and Mrs. Bird Daniel, of Statesboro.*

This hotel, containing 2,000 rooms and called "the best hotel in Moscow," was designed by a French architect and completed in 1980 for the Olympic games. The exterior of the golden, arc-shaped building is attractive. The interior, however, is quite different from first-class American hotels. Colors are dark and drab; halls and rooms are musty and inadequately cleaned. The guests found no washclothes in the bathrooms. Towels were small and worn. The water could not be used for drinking or brushing teeth. Most guests bought bottles of water or soft drinks (orange or Pepsi-Cola) from a stand in the hotel lobby.

The first big difference between the U.S.S.R. and the United States became obvious when the visitors sat

*Evelyn Ward Gay is a freelance writer.*

*There were few restrictions on picture-taking in the U.S.S.R. Shown here is St. Basil's Cathedral from Red Square in Moscow.*

down for meals. The hosts had planned their very best foods, but there was a noticeable lack of fresh vegetables and fruits, together with a sameness and a blandness hard to ignore. Yet the food, while carefully rationed, was ample and nutritious—and interesting. Few complaints were heard, and the travelers were "rewarded" often with vodka and caviar, obviously the Russians' idea of pampering Americans.

Moscow had been described as the "cultural, emotional, and spiritual heart of the U.S.S.R.," and one of the most popular of the city's attractions, called the Exhibition of National Economic Achievements, is located directly across the street from the Cosmos Hotel. An area of over 300 hectares (1 hectare equals 2.47 acres), it is the site of some 80 pavilions and open squares containing exhibits detailing the country's development, as well as the promotion of culture, science, education, and other aspects of Soviet life.

It was in a building in this extensive complex that the American physicians got their first look at the Soviet health care system. They were greeted by a female obstetrician and a male surgeon. Discussions followed on several problems shared by Americans and Russians, including teenage pregnancy, premature birth weights, alcohol and drug abuse, and cancer. They learned that these problems are as difficult to solve in the U.S.S.R. as they are in the United States. As a part of Soviet leader Gorbachev's drive to cut down on alcoholism, a new sobriety law has been enacted, by which stores in Russia which sell alcohol are open only during certain hours, and a person is allowed to buy only a limited quantity. The Russian physicians claim that this law has helped decrease the accident rate 40 percent in the past year. As for trying to control lung cancer, they admitted that there are as yet no bans on smoking, and many Russians smoke cigarettes.

The Soviet medical system was explained by the Russian physicians. All medical doctors, who are educated by the government in a much shorter time than those in the United States, are employed by the state, and salaries begin at about the equivalent of $300 per month. Medical professors draw a little more, plus research funds. The medical profession is not held in high esteem by the Russians, however. The less desirable occupations, such as that of truck driver, receive higher pay to attract more people. In Russia, almost 90 percent of physicians are women. This is due, they claim, to the fact that more women than men qualify by examination for medical studies, but obviously due also to the fact that men are placed in higher-paying jobs. However, they say, an effort is being made to recruit more men into the profession.

Popular literature distributed by the Soviets declares that "The most progressive and humane principles lie behind the Soviet health system—accessibility to all, free medical care, and an illness-prevention orientation." This is assured, they claim, by maintaining a sufficient number of doctors and medical institutions. They are proud to state that the U.S.S.R. takes first place in the world in the number of doctors employed.

All forms of medical care are provided free of charge, including surgery and hospital care. The people must pay only for medicines, although in-patients and all children under the age of one year, and a few other groups such as the elderly, receive free medication.

No deductions are made from wages to pay for this medical care. Patients also receive benefits for temporary disability. This can equal 50 percent to 100 percent of wages, depending upon seniority.

The U.S.S.R. maintains that it stresses "preventive measures" to all citizens, in order to improve working and living conditions and to stamp out infectious diseases, by providing a network of "therapeutic establishments." Healthy activities are encouraged for all ages, and sports facilities are numerous. At present, the average life expectancy in the U.S.S.R. is said to be 71 years.

After the round-table discussions at the Exhibition of National Economic Achievements, the visiting physicians were escorted on a tour of the Health Pavilion, followed by a look at space accomplishments, including an exhibit commemorating the joint U.S.-Soviet space efforts.

The tour group enjoyed a ride on the underground train called the *Metropoliten* (or *Metro*) whose first line was opened in 1935. Deservedly called "the finest in the

world," the subway system is a showplace of marble, bronze and giant chandeliers. Escalators, which move at an exhilaratingly fast speed, are seven stories tall. To ride them costs five kopeks each way, or about the equivalent of seven cents in U.S. coins. The visitors were told that there is little crime in Moscow, and vandalism is not tolerated on the subway or elsewhere in the U.S.S.R.

A highlight of the tour was a visit to the Kremlin and Red Square, located in the heart of the capital city. On one side of Red Square is the tomb of Vladimir Lenin, the Soviet Union's revolutionary hero, whose embalmed body is viewed daily by mobs of people from all parts of the world.

The Kremlin, called "the shrine and mecca for all Soviet peoples for centuries," but in reality the center of government and politics, is nearby on the left bank of the Moscow River. It began as a wooden structure in 1147, but the walls and 20 Kremlin towers of red brick were not erected until the late 15th century. Five of the towers have been crowned with ruby stars since 1937. Cathedral Square lies at the center of the Kremlin. Here are located several ancient cathedrals displaying some of the most beautiful frescoes in the world, and numerous unique examples of old Russian art of the 11th-17th centuries, including icons from many famous craftsmen.

Shopping in the U.S.S.R. was a new experience for the Americans. Small areas called *Beriozkas* (meaning "birch tree" in Russian) are located in hotels and at various other places. In these shops, operated solely for tourists, foreign currency and major credit cards may be used without having to convert money into rubles. A few items of clothing and all kinds of souvenirs may be purchased at reasonable prices.

The visit to Moscow was climaxed on the last evening there by a fast-paced concert at Tchaikovsky Hall presented by a group of about 50 talented young people from Siberia.

From Moscow, the travelers flew via *Aeroflot* to the ancient city of Kazan, located 750 km to the northeast. This short flight confirmed the visitors' first impression of the Soviet Union's air service. While the state airline supposedly has a good safety record, the airplanes are old, dirty, and uncomfortable. Employees for the most part were unfriendly, slow, and inefficient. Airport facilities in the entire country were found to be less than functional. There were no drinks, food, or other necessities available. Restroom accomodations were unbelievably primitive, filthy, and almost unusable. In most of them, there was no running water or flushing mechanism.

Planes were boarded after taking a considerable walk from the door of the airport building to a dilapidated bus with standing room only which bounced the people about on a rough ride across the airfield.

After arriving at the airport on the outskirts of Kazan, the Americans were taken by tour bus into the city along a route that passed flat farmland and green forests. A guided tour of the city followed lunch in an upstairs restaurant located in a building which appeared to be clean and was tastefully decorated.

Kazan, with a population of a million people, made up of 70 various nationalities, was incorporated into the Russian state in the mid-16th century during the reign of Ivan the Terrible, and has served as the capital of the Tartar (Tatar) Autonomous Soviet Socialist Republic since May of 1920. It played a leading role in the great peasant uprisings of 1773-1775, and in the first Russian Revolution of 1905-07. Today it is an industrial city whose plants produce powerful compressors, airplanes, electronic computers, and refrigerators, among other modern-day products.

*The Kremlin, viewed from across the Moscow River, is called "the shrine and mecca for all Soviet citizens for centuries."*

Kazan also has its own Kremlin, characterized by white stone walls and towers built in the mid-16th century. The walls enclose some magnificent examples of unique architecture. The city's famous Kazan University, founded in 1804, was the place where the first Marxist student groups were formed. It was here, too, that in July of 1887, 17-year-old Vladimir Ulyanov (later to be known as Lenin) became a student in the law school.

Sanitary conditions everywhere were appalling. It was in Kazan that the travelers first witnessed a few incidents

which belied the Russians' claims to having a successful system of preventing infectious diseases. The weather was hot and dry at mid-afternoon, and a cold drink would have been welcome, but there were no machines dispensing bottled or canned drinks, or even water fountains. No grocery stores were available along the main thoroughfares. One small plaza with a few tables and chairs was pointed out by the guide. Inside a corner shop several young people behind a counter dished out ice cream (vanilla only) into small containers to be eaten with wooden paddles. The containers were then rinsed in tap water and served to the next customer. Outside on the plaza was a wooden shed where a glass filled with either orange or lemonade drink could be had by inserting a coin into a slot. After drinking it, the customer rinsed the glass in tap water and returned it for the next person who was thirsty enough to use it. Along the streets, mobs of people, many of them with small children, left the crowded sidewalks and walked through trash and stagnant water in the gutters, seeming unaware of the dirt and filth clinging to their shoes.

In spite of the lack of cleanliness that abounded, the visitors found the people of Kazan to be very warm and friendly. Like the inhabitants of other areas, they were eager to exchange small gifts (usually a lapel pin with a ruby star) for ballpoint pens or anything from America. Some of them spoke English but most conversations had to be interpreted by one of the guides. The general theme was that all the Russian people wanted was peace with all nations. A reply that the Americans also wanted peace brought only disbelief to the worried faces of the Russians.

*On a street in Kazan, Dr. and Mrs. Don Printz, of Stone Mountain, (in background) look at polaroid pictures they have taken with two Russian citizens. At right is Duluth, Ga. businessman Lloyd Bird.*

One of the most important distinctions of the city of Kazan today is that it is the starting and finishing point for Volga-Don River cruises. It was there that the Americans boarded the *Alexander Pushkin* for a delightful 8-day cruise to view the beautiful Russian countryside, with several stops along the way to meet the natives and observe first-hand their various lifestyles.

The *Alexander Pushkin,* named for one of the U.S.S.R.'s most revered literary figures, is an impeccably clean and comfortable ship. Built in Austria in 1974 and powered by the most up-to-date electronic and navigational equipment, it was designed especially for cruising the Volga and Don Rivers.

At boarding, a special treat greeted the tourists. "America, the Beautiful" and several other familiar tunes, played by a Russian band on the top deck, floated out across the tired crowd.

The Volga River, said to be "venerated by poet, priest, peasant and musician," is the largest river in Europe, flowing 2,500 miles and draining an area of a million square miles. Through a system of canals, it carries millions of tons of cargo a year and thousands of passengers on boats ranging from those like the *Alexander Pushkin* to high-speed hydrofoils. In some places the river is 5 miles wide. Along its banks where great cities rise today, the Red Army once fought heroic battles against the enemies of the young socialist state, and here also the Soviet Union survived the horrors of Nazi warfare during World War II.

The first stop along the river was at the town of Ulyanovsk, named in honor of Lenin's family. Here a morning visit had been arranged at a kindergarten school for children 2 to 7 years of age. A select group of children, all solemn-faced and serious, the little girls wearing big fluffy bows in their hair, the little boys in short pants, greeted the visitors with bouquets of colorful flowers which they gave to each guest.

The school, called "The Sun," was neat and clean thoroughout, and the teachers seemed genuinely devoted to the students. The school has its own clinic with a resident woman physician on the staff. In one of the larger classrooms, while the tourists sat on the small, colorfully decorated chairs, the children entertained them with a song and dance routine, always with the theme "We want peace." It was in this school also that the early childhood worship of Lenin, which permeates the life of all Russians, became evident. The walls were decorated with large yellow paper cut-outs of the sun, but holding a dominant spot in the front of the room was a large framed photograph of the man who has become their hero. Running throughout the enter-

*Dr. William D. Logan, of Atlanta, (second from left in center) joined other visitors to play games with the children at the Pioneer Camp in Togliatti. In front of Dr. Logan is Dr. Ray Newman, a pediatrician from Pennsylvania.*

taining program were the words "Father Lenin says be good little boys and girls," and it was clear that this dictum was stressed daily with good results.

A visit to one of Lenin's early homes followed the trip to the kindergarten. In the afternoon the visitors were escorted on a tour of the Lenin Memorial Museum at the local university. Sitting atop a high hill, and offering a spectacular view of the city below, this museum is built of marble and is very modern in design.

In the evening, a 10-minute bus ride from the ship took the visitors to the city's civic center auditorium for what was billed as a "Friendship Meeting." At least 200 people were in the large room as the Americans filed in and took seats reserved for them in front. Applause greeted their entry, followed by a cordial welcome by the female head of a local workers union.

After a musical program presented by amateur performers, including several numbers by a Russian rock group, the guests were invited to the foyer where a band played American and Russian music for dancing, and where several humorous games were played with people from both countries taking part. They were encouraged to introduce themselves and to exchange names and addresses in order to promote friendship between the nations.

The next day the travelers went ashore for a visit to the new town of Togliatti. Along the bus route were a few single family houses, very small and rundown, with small garden plots, which the guide said are privately owned by some of the people. Most of the housing here, as in all parts of Russia, is in multiple-story apartment buildings.

The entire area is dotted with residence complexes, called *micro-areas,* each with high-rise apartments built around a garden and with school, market, a "sports yard," several hospitals and clinics, and every facility needed by the people of that complex.

The town's location was a thick forest until about 15 years ago when it was first settled around a new industry begun with the aid of an Italian company to manufacture automobiles. The local plant, which has its own technical school where workers and engineers are trained, is now said to be one of the largest car manufacturers in the world and turns out one car every 23 seconds, all patterned after the Italian Fiat. Yet only 1 in 3 Russian families owns an automobile.

A stop at a "Pioneer Camp" for young Communists (similar to an American YMCA camp) completed the visit to Togliatti. Here children between the ages of 7 and 15 years, both boys and girls, stay for 3 weeks during the summer. The families pay a small fee amounting to about 30 percent of the cost, which is supplemented from a union fund. The living quarters were clean and well-kept, the children again stoic, obedient, and unsmiling as they went about their assigned tasks of showing off their camp to the Americans and participating in relay races and several other lively games.

Following a short stop on Maiden Island for a picnic

and dance around a bonfire and a full day's cruise along the river, the boat reached Volgograd, a reconstructed city on the site of the old city of Stalingrad which was destroyed by the Germans during World War II. Only one remnant of the carnage which took place there is still standing—the gutted ruins of a flour mill. A visit to *Mother Russia,* called "the largest statue in the world," and a lecture on the atrocities committed by the Germans during 1941-1942, sent the Americans back to the ship with a new understanding of the Russian people's constant fears of future invasion which remain a part of their lives today.

After another day and night of cruising, during which the boat passed through the 35-mile-long Volga-Don Canal via 13 sets of locks, the group arrived at Rostov-on-the-Don. A city tour was followed by a visit to a collective farm and the private home of a bus driver. Rostov-on-the-Don was the final stop on the cruise where passengers disembarked to continue the Journey of the Czars.

The Volga-Don River cruise had been a most informative and entertaining week for the Americans. On board for the entire trip had been Dr. Ronald Rader, a professor of Russian History at the University of Georgia, and a Russian sociologist from Moscow named Vsevolod Marinov. These men led many lively discussions on various aspects of life in the U.S.S.R., and while their views often differed, they gained a healthy respect for each other before the trip was over. At the end of the cruise, the two speakers were roundly applauded by the travelers and presented with certificates of appreciation signed by all of them.

On board the ship also, the physicians attended medical seminars conducted by Dr. Robert Baldwin, from the University of Alabama in Birmingham. And in contrast to the more serious programs held during the cruise, the tourists enjoyed several shipboard entertainments in which both the Russian crew and the American visitors took part in songs, dances, and high drama.

The final three days of the journey were spent in Leningrad after a flight from Rostov-on-the-Don. There the Americans were booked into the Pribaltiyskaya Hotel (the name meaning "by the Baltic Sea"), a large European-style hotel with good facilities.

Leningrad, formerly known as St. Petersburg and "Peter the Great's Window on Europe," is a pretty city with wide streets, many parks, and row upon row of high-rise apartment buildings. Located on the Neva River, Leningrad has a population of 4,000,000 and is the second largest city in the U.S.S.R. The workmanship on the buildings is much better than that seen in Moscow and other sections of the country. Much new building is going on and the city seemed clean and the

*On board the Alexander Pushkin which cruised the Volga-Don Rivers are Dr. and Mrs. David Williams, of Augusta.*

people more industrious. Named a "hero city" because it withstood a blockade and siege of 900 days during World War II, the city shows few scars today and has been completely restored.

In Leningrad, the physicians visited a pediatric polyclinic, one of 7 clinics in the district. In a classroom, the head of the clinic, a friendly woman about 35 years of age, explained the Soviet system where the mother is followed through pregnancy and the baby is cared for up to 15 years. Again, she said that doctors tried to "practice preventive medicine." Babies come back for exercises and advice to mothers about care, she said.

The American doctors were given a tour of the clinic during which they saw a Russian doctor treating a child with a sore throat using a quartz light for several minutes. No other medication was being given. This treatment, they said later, went out of use in the United States in the 1930s.

At the end of the visit, the American physicians gave the head of the clinic several issues of *Pediatric Clinics of North America.*

While in Leningrad, the Americans also toured *The Hermitage,* once the winter palace fo the Czars, but today the U.S.S.R.'s most famous art museum where many of the world's richest art treasures of the 15th – 18th centuries are kept.

Another interesting tour while in Leningrad included *Petrodvorets,* the summer palace of the Czars located on the Gulf of Finland and reached after a 30-minute ride via a fast-speed hydrofoil boat up the Neva River. Begun in 1704 by Peter the Great, and expanded by a succes-

sion of Russian royalty, the main building is reached by walking up 150 steps past numerous gold statues and fountains. Many of the furnishings of the palace and valuable paintings had been hidden by the Russians before the building was destroyed partially during World War II. Much of it was returned, however, after the war, and restoration, still incomplete in some of the rooms, was begun in 1946.

An afternoon tour took the tourists to the Peter and Paul Fortress, founded in 1703, which required 30 years to complete. Three generations of Russian revolutionaries, mostly opponents of the Czarist regime, were jailed in its cells, but the fortress is now a museum surrounded by Lenin Park.

The Journey of the Czars ended in Leningrad with a spectacular performance at the circus where a big tent packed the spectators in on hard wooden benches with no backs.

*At a farewell dinner at the Pribaltyiskaya Hotel in Leningrad, Dr. and Mrs. Brit Gay of Emory University (left rear) are seated with Dr. and Mrs. Earl Roles, of Louisville, Ky. (front) and Mabel Doremus and Hollywood actor David Schroeder, both of Los Angeles (right rear).*

* * *

While the physicians on the tour had attended round-table discussions, talked with their Russian counterparts, and visited medical facilities in several locations, this writer had an unscheduled personal experience behind the scenes of the U.S.S.R.'s medical care system.

At the conclusion of the visit to the Pioneer Camp at Togliatti, a fall on a wet stone step resulted in a Colle's fracture of the left wrist and a sprained right ankle. On the back seat of one of the tour buses, a makeshift splint was fashioned with the tour director's sweater, two Russian newspapers, and the laces from a wife's running shoes.

Back at the riverside, an ambulance was called. A half hour later the outmoded and poorly-equipped vehicle arrived with a crew made up of the male driver, a male physician, and two female assistants—all very friendly and compassionate people, but none of whom spoke English.

The 20-minute ride to the hospital's emergency clinic was over rough, winding, unpaved roads, but there was no long wait for a doctor. The patient was escorted immediately to a slow elevator that was barely operating for a ride to an upper floor surgery department. There an X-ray was made of the injured wrist by a silent female technician using a machine whose best days had long since passed.

A stern, grim-faced physician (a small man wearing glasses and a starched white baker's-style hat) silently examined and taped the sprained ankle, looked at the wet X-ray handed to him by the technician, and hustled the patient into another small, barren room.

The doctor was assisted by a tall, muscular man (presumably a physician or a physician's assistant) with a broad smile, and two female nurses. The head nurse pulled a hypodermic needle with forceps from a mass of needles which were tangled together in a tin box. Noting the patient's uneasy interest in what was about to take place, the head doctor took a small bottle from a shelf and held it in front of the patient's face. On it was the word *novocain* written in English.

Mission accomplished, the patient, sporting a Russian-style left forearm plaster cast, supported by a sling made out of a narrow strip of gauze tied in a knot at the neck, was escorted by the tall, pleasant gentleman toward the elevator. It was no longer operating. After walking down several flights of shabby steps, the patient was delivered to the waiting room where an entourage from the ship waited along with the ambulance crew. X-rays, now almost dry, and a certificate of service, handwritten in Russian by the smiling assistant, were given to the patient as evidence of a memorable visit by an American tourist to a free Russian clinic.

Upon reboarding the ship, it was discovered that one of the physicians had been taken ashore earlier with an abscessed tooth for a visit to a Russian dental clinic. Experiences were compared and were found to be similar.

After much discussion among the American physicians on the Journey of the Czars, the concensus was that Russian medicine, unlike American medicine, is practiced "with few advantages and no frills."

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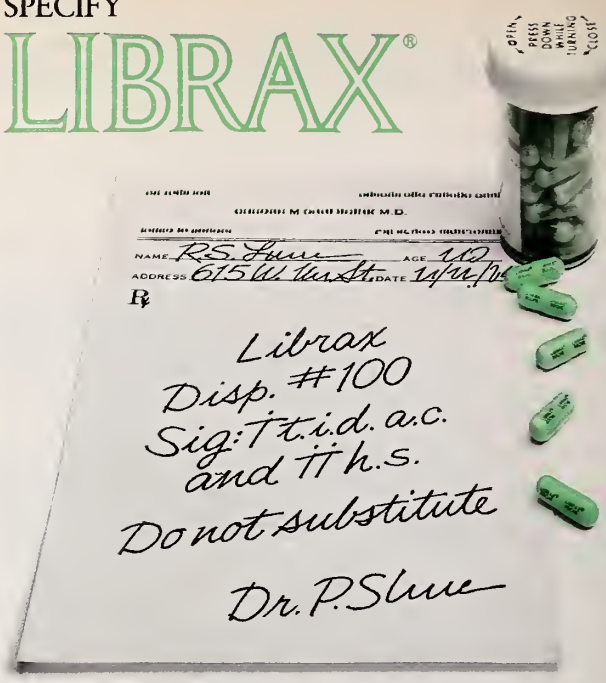


Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

*Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE®

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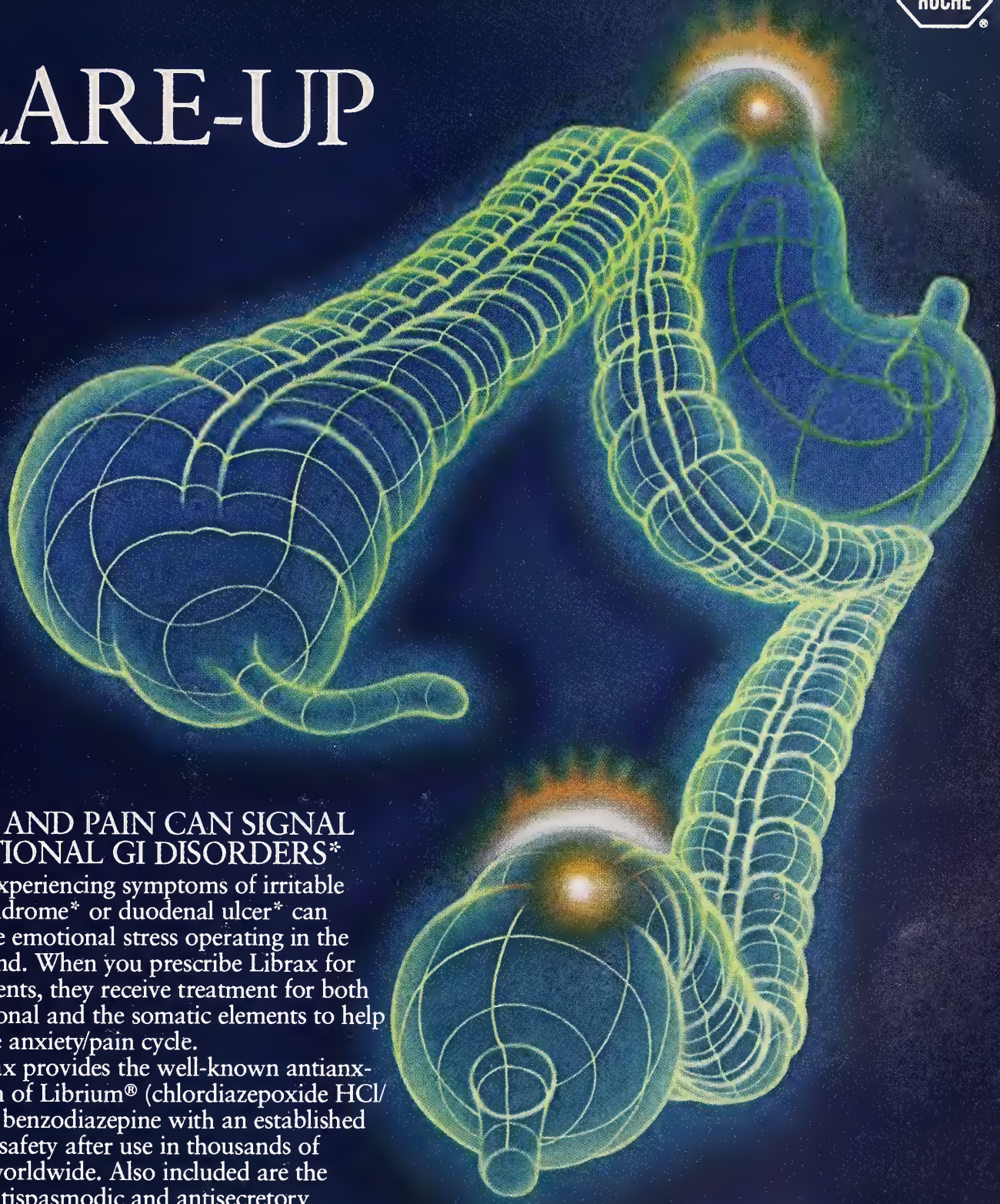
# FLARE-UP



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*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of duodenal ulcer and the irritable bowel syndrome.

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**Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.**

**WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

**Contraindications:** Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum $K^+$ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict $K^+$ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

**Precautions:** The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

**Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.**

BRS-DZ:L42

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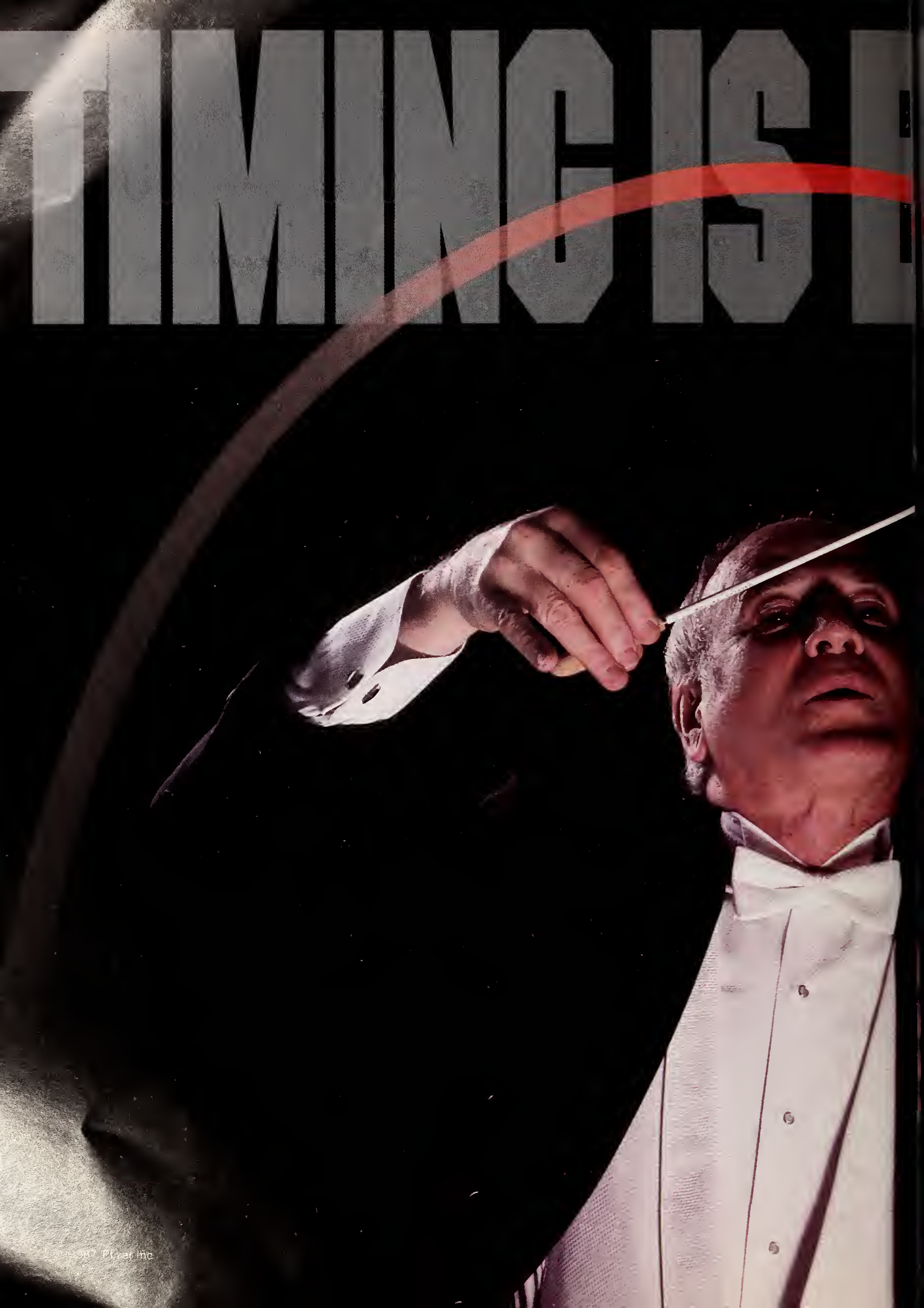


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# VERYTHING

## Effective control time and time again[1]

Effective control of fasting and postprandial glucose—patient after patient, meal after meal, year after year.

## Insulin when it's needed

Insulin levels are rapidly elevated in response to a meal, then return promptly to basal levels after the meal challenge subsides.

## Timed to minimize risks

Rapidly metabolized and excreted, with an excellent safety profile.[1] As with all sulfonylureas, hypoglycemia may occur.

**In concert with diet in non-insulin-dependent diabetes mellitus**

# Glucotrol®

(glipizide) 5-mg and 10-mg Scored Tablets

## SYNCHRONIZED SULFONYLUREA THERAPY

*Please see brief summary of Glucotrol® (glipizide) prescribing information on next page.*

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

References:
1. Sachs R, Frank M, Fishman SK: Overview of clinical experience with glipizide. In *Glipizide: A Worldwide Review*. Princeton, NJ, Excerpta Medica, 1984, pp 163-172.

**GLUCOTROL® (glipizide) Tablets**

**Brief Summary of Prescribing Information**

**INDICATIONS AND USAGE:** GLUCOTROL is indicated as an adjunct to diet for the control of hyperglycemia in patients with non-insulin-dependent diabetes mellitus (NIDDM, type II) after an adequate trial of dietary therapy has proved unsatisfactory.

**CONTRAINDICATIONS:** GLUCOTROL is contraindicated in patients with known hypersensitivity to the drug or with diabetic ketoacidosis, with or without coma, which should be treated with insulin.

**SPECIAL WARNING ON INCREASED RISK OF CARDIOVASCULAR MORTALITY: The administration of oral hypoglycemic drugs has been reported to be associated with increased cardiovascular mortality as compared to treatment with diet alone or diet plus insulin. This warning is based on the study conducted by the University Group Diabetes Program (UGDP), a long-term prospective clinical trial designed to evaluate the effectiveness of glucose-lowering drugs in preventing or delaying vascular complications in patients with non-insulin-dependent diabetes. The study involved 823 patients who were randomly assigned to one of four treatment groups (*Diabetes*, 19, supp. 2:747-830, 1970).**

**UGDP reported that patients treated for 5 to 8 years with diet plus a fixed dose of tolbutamide (1.5 grams per day) had a rate of cardiovascular mortality approximately 2-1/2 times that of patients treated with diet alone. A significant increase in total mortality was not observed, but the use of tolbutamide was discontinued based on the increase in cardiovascular mortality, thus limiting the opportunity for the study to show an increase in overall mortality. Despite controversy regarding the interpretation of these results, the findings of the UGDP study provide an adequate basis for this warning. The patient should be informed of the potential risks and advantages of GLUCOTROL and of alternative modes of therapy.**

**Although only one drug in the sulfonylurea class (tolbutamide) was included in this study, it is prudent from a safety standpoint to consider that this warning may also apply to other oral hypoglycemic drugs in this class, in view of their close similarities in mode of action and chemical structure.**

**PRECAUTIONS: Renal and Hepatic Disease:** The metabolism and excretion of GLUCOTROL may be slowed in patients with impaired renal and/or hepatic function. Hypoglycemia may be prolonged in such patients should it occur.

**Hypoglycemia:** All sulfonylureas are capable of producing severe hypoglycemia. Proper patient selection, dosage, and instructions are important to avoid hypoglycemia. Renal or hepatic insufficiency may increase the risk of hypoglycemic reactions. Elderly, debilitated or malnourished patients and those with adrenal or pituitary insufficiency are particularly susceptible to the hypoglycemic action of glucose-lowering drugs. Hypoglycemia may be difficult to recognize in the elderly or people taking beta-adrenergic blocking drugs. Hypoglycemia is more likely to occur when caloric intake is deficient, after severe or prolonged exercise, when alcohol is ingested, or when more than one glucose-lowering drug is used.

**Loss of Control of Blood Glucose:** A loss of control may occur in diabetic patients exposed to stress such as fever, trauma, infection or surgery. It may then be necessary to discontinue GLUCOTROL and administer insulin.

**Laboratory Tests:** Blood and urine glucose should be monitored periodically. Measurement of glycosylated hemoglobin may be useful.

**Information for Patients:** Patients should be informed of the potential risks and advantages of GLUCOTROL, of alternative modes of therapy, as well as the importance of adhering to dietary instructions, of a regular exercise program, and of regular testing of urine and/or blood glucose. The risks of hypoglycemia, its symptoms and treatment, and conditions that predispose to its development should be explained to patients and responsible family members. Primary and secondary failure should also be explained.

**Drug Interactions:** The hypoglycemic action of sulfonylureas may be potentiated by certain drugs including nonsteroidal anti-inflammatory agents and other drugs that are highly protein bound, salicylates, sulfonamides, chloramphenicol, probenecid, coumarins, monoamine oxidase inhibitors, and beta adrenergic blocking agents. *In vitro* studies indicate that GLUCOTROL binds differently than tolbutamide and does not interact with salicylate or dicumarol. However, caution must be exercised in extrapolating these findings to a clinical situation. Certain drugs tend to produce hyperglycemia and may lead to loss of control, including the thiazides and other diuretics, corticosteroids, phenothiazines, thyroid products, estrogens, oral contraceptives, phenytoin, nicotinic acid, sympathomimetics, calcium channel blocking drugs, and isoniazid. A potential interaction between oral miconazole and oral hypoglycemic agents leading to severe hypoglycemia has been reported. Whether this interaction also occurs with the intravenous, topical, or vaginal preparations of miconazole is not known.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** A 20-month study in rats and an 18-month study in mice at doses up to 75 times the maximum human dose revealed no evidence of drug-related carcinogenicity. Bacterial and *in vivo* mutagenicity tests were uniformly negative. Studies in rats of both sexes at doses up to 75 times the human dose showed no effects on fertility.

**Pregnancy:** Pregnancy Category C: GLUCOTROL (glipizide) was found to be mildly fetotoxic in rat reproductive studies at all dose levels (5-50 mg/kg). This fetotoxicity has been similarly noted with other sulfonylureas, such as tolbutamide and tolazamide. The effect is perinatal and believed to be directly related to the pharmacologic (hypoglycemic) action of GLUCOTROL. In studies in rats and rabbits no teratogenic effects were found. There are no adequate and well controlled studies in pregnant women. GLUCOTROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Because recent information suggests that abnormal blood glucose levels during pregnancy are associated with a higher incidence of congenital abnormalities, many experts recommend that insulin be used during pregnancy to maintain blood glucose levels as close to normal as possible.

**Nonteratogenic Effects:** Prolonged severe hypoglycemia has been reported in neonates born to mothers who were receiving a sulfonylurea drug at the time of delivery. This has been reported more frequently with the use of agents with prolonged half-lives. GLUCOTROL should be discontinued at least one month before the expected delivery date.

**Nursing Mothers:** Since some sulfonylurea drugs are known to be excreted in human milk, insulin therapy should be considered if nursing is to be continued.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:** In controlled studies, the frequency of serious adverse reactions reported was very low. Of 702 patients, 11.8% reported adverse reactions and in only 1.5% was GLUCOTROL discontinued.

**Hypoglycemia:** See PRECAUTIONS and OVERDOSAGE sections.

**Gastrointestinal:** Gastrointestinal disturbances, the most common, were reported with the following approximate incidence: nausea and diarrhea, one in 70; constipation and gastralgia, one in 100. They appear to be dose-related and may disappear on division or reduction of dosage. Cholestatic jaundice may occur rarely with sulfonylureas. GLUCOTROL should be discontinued if this occurs.

**Dermatologic:** Allergic skin reactions including erythema, morbilliform or maculopapular eruptions, urticaria, pruritus, and eczema have been reported in about one in 70 patients. These may be transient and may disappear despite continued use of GLUCOTROL; if skin reactions persist, the drug should be discontinued. Porphyria cutanea tarda and photosensitivity reactions have been reported with sulfonylureas.

**Hematologic:** Leukopenia, agranulocytosis, thrombocytopenia, hemolytic anemia, aplastic anemia, and pancytopenia have been reported with sulfonylureas.

**Metabolic:** Hepatic porphyria and disulfiram-like alcohol reactions have been reported with sulfonylureas. Clinical experience to date has shown that GLUCOTROL has an extremely low incidence of disulfiram-like reactions.

**Endocrine Reactions:** Cases of hyponatremia and the syndrome of inappropriate antidiuretic hormone (SIADH) secretion have been reported with this and other sulfonylureas.

**Miscellaneous:** Dizziness, drowsiness, and headache have been reported in about one in fifty patients treated with GLUCOTROL. They are usually transient and seldom require discontinuance of therapy.

**OVERDOSAGE:** Overdosage of sulfonylureas including GLUCOTROL can produce hypoglycemia. If hypoglycemic coma is diagnosed or suspected, the patient should be given a rapid intravenous injection of concentrated (50%) glucose solution. This should be followed by a continuous infusion of a more dilute (10%) glucose solution at a rate that will maintain the blood glucose at a level above 100 mg/dL. Patients should be closely monitored for a minimum of 24 to 48 hours since hypoglycemia may recur after apparent clinical recovery. Clearance of GLUCOTROL from plasma would be prolonged in persons with liver disease. Because of the extensive protein binding of GLUCOTROL (glipizide), dialysis is unlikely to be of benefit.

**DOSAGE AND ADMINISTRATION:** There is no fixed dosage regimen for the management of diabetes mellitus with GLUCOTROL; in general, it should be given approximately 30 minutes before a meal to achieve the greatest reduction in postprandial hyperglycemia.

**Initial Dose:** The recommended starting dose is 5 mg before breakfast. Geriatric patients or those with liver disease may be started on 2.5 mg. Dosage adjustments should ordinarily be in increments of 2.5-5 mg, as determined by blood glucose response. At least several days should elapse between titration steps.

**Maximum Dose:** The maximum recommended total daily dose is 40 mg.

**Maintenance:** Some patients may be effectively controlled on a once-a-day regimen, while others show better response with divided dosing. Total daily doses above 15 mg should ordinarily be divided.

**HOW SUPPLIED:** GLUCOTROL is available as white, dye-free, scored diamond-shaped tablets imprinted as follows: 5 mg tablet—Pfizer 411 (NDC 5 mg 0049-4110-66) Bottles of 100; 10 mg tablet—Pfizer 412 (NDC 10 mg 0049-4120-65) Bottles of 100.

CAUTION: Federal law prohibits dispensing without prescription.

**More detailed professional information available on request.**

ROERIG Pfizer A division of Pfizer Pharmaceuticals
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# Georgia Health Network

## More Than An HMO

*S. William Clark, M.D.*
*President, Georgia Health Network*

In 1985, the Medical Association of Georgia embarked upon a venture in medical economics that was unique at the time and remains unparalleled in terms of its scope and its ambitions for the profession of medicine. Since then, four other state medical societies have replicated our experiment, and some 20 more are in varying stages of study and development.

The product of our efforts in Georgia was the first medical society-sponsored, statewide IPA in the country, which we call Georgia Health Network (GHN). From the outset, GHN has been the subject of intense, continuing scrutiny by our sister medical societies around the country, by insurance companies of all sizes and stripes, by the Federal Trade Commission, the press, and our own community of MAG physicians. Reactions have ranged from open admiration to suspicion, skepticism, and outright hostility. On the whole, the results of our work fall somewhere between the euphoric victory envisioned by some and the dismal failure predicted by others, but clearly much nearer the former than the latter.

***GHN is the only vehicle that can accomplish what so many of us want — a means for physicians to act together to advance our personal interests and the interests of our patients and our profession.***

### Theory and Structure

The shorthand term, "IPA/HMO," does a great disservice to the thoughtfully crafted structure of our MAG venture. The term usually denotes an HMO that has created its own captive IPA whose physician members have agreed to deep fee concessions, severe utilization regimens, and often the assumption of substantial insurance risk through "capitation" reimbursement arrangements. Unfortunately, some of our own MAG members think of GHN as "just another alternative delivery system," or worse yet, "just another HMO."

Georgia Health Network is our own physician-controlled, stand-alone IPA whose mission is indisputably pro-physician. GHN has dealt and will continue to deal from a totally physician-oriented standpoint with all players in the volatile arena of medical finance.

GHN's very first contract was a joint venture PPO arrangement in Albany. GHN physicians made no fee concessions, all "professional aspects" (credentialing, utilization review, and peer review) are controlled by GHN, and some 11,500 patients

have been directed to GHN physicians in that area of Georgia.

The IPA Steering Committee that worked so diligently to bring GHN into being operated with several philosophic points in mind.

First, the IPA venture would always be a MAG-controlled, pro-physician entity. Thus, MAG holds total voting control of both the IPA and its companion entity, the HMO. And the IPA President reports regularly to the MAG Board of Directors, just as do the presidents of other MAG-sponsored ventures.

***Our initial marketing success has been in middle Georgia, where almost 85% of the practicing physicians are in the MAG IPA.***

Second, the mission of the IPA would be to serve the best interests of its member physicians in dealings with third party payors, *including* our own, captive HMO. We would not agree to "across the board" fee discounts, but we would agree to reasonable upper-limits or to incentive reimbursement systems. We would fight against "gatekeeper" and "capitation" reimbursement arrangements. We would agree to reasonable credentialing, utilization review, and peer review procedures, but only if they were controlled and directed by our own physician members.

And finally, our IPA had to be structured within the constraints of federal antitrust laws. In order for us to act together in the marketplace, it was necessary that we "pool capital" and "share risks." Thus, we required a substantial financial contribution from our participating physicians. And, with respect to our own HMO and in our negotiations with PPO prospects, we have adopted reimbursement methodologies in which a portion of each physician's fee is placed "at risk," to be refunded to that physician if we — all of us — are as successful as we believe we can be in controlling medical costs.

### The First Year

*PPO*

Clearly, GHN is not "just another HMO." A major thrust of our efforts has been toward PPO arrangements. In addition to the Albany PPO, we are working toward the creation of PPO relationships with a number of moderate-size employee and union groups that will be of some consequence in specific areas of the state. More important, we are moving toward relationships with major indemnity insurance carriers who recognize that GHN — and only GHN — can provide the PPO and HMO legs of the so-called "triple option" statewide.

In all these negotiations, the other players have come to the table thinking in terms of straight "fee discounts." In every case, we have convinced them that this kind of simplistic approach to cost containment is unfair to physicians, because it penalizes the efficient, low-cost physician as much as the high-cost practitioner; is ineffective, because the medical marketplace will "adjust" promptly to the presence of discounts; and otherwise is not in the best interest of quality medical care for their "insureds" who are our "patients." We have argued, rather, in favor of reasonable fee ceilings, coupled with physician incentives for cost control that do not impact the quality of patient care.

To the extent we have been successful in changing the way these major insurance players perceive the issue of physician reimbursement — and we believe some of the negotiations are approaching fruition — we have accomplished a major objective of our venture, which has been to represent the interests of the physician community in shaping the emerging medical marketplace.

*CHAMPUS*

Recent moves by the Department of Defense (DoD) to radically overhaul the CHAMPUS program highlight the volatility of the medical marketplace. This program of medical care for service dependents and retirees spends about $1.5 billion annually; CHAMPUS spends about *$100 million annually* for physician and hospital services in Georgia.

***GHN's first contract was a joint venture PPO arrangement in Albany in which GHN physicians made no fee concessions, all "professional aspects" (credentialing, utilization and peer review) are controlled by GHN, and some 11,500 patients have been directed to GHN physicians. . . .***

When DoD announced plans to contract out the CHAMPUS program to large insurance companies on a "fixed fee" (i.e., capitated) basis, we realized immediately the potentially disastrous impact upon Georgia physicians practicing near major military installations, of which there is at least one in every large city in Georgia. The CHAMPUS initiative is far too complicated to discuss here, but suffice it to say that the MAG IPA has been in continuous contact since last spring with William Mayer, M.D., Assistant Secretary of Defense for Health Affairs, and Congressman J. Roy Rowland, M.D., of Dublin, on the subject.

After Congress reined in DoD and ordered a pilot study of the proposed reforms, DoD picked Georgia as one of the test sites. One of the reasons given was the presence of our physician-driven, statewide delivery ca-

pability, which is unique in the country. In our discussions with DoD officials, we argued that a physician-driven delivery system is better able to control costs and quality of care than a hospital-driven system. It appears they have now invited the physicians of Georgia to demonstrate our ability to do so.

The future of CHAMPUS reform is far from clear. But if it proceeds as planned, physicians must be represented at the table before the contracts are let, or we will have little or no bargaining position with whoever wins control over a $100 million annual slice of the medical marketplace in Georgia. The *only* entity that can represent physicians statewide in Georgia is the MAG IPA. We clearly do not intend to assume any direct insurance risk in the CHAMPUS program, but we do want to be a recognized co-bidder with a company that does, having negotiated in advance those points of primary interest to our member physicians: reimbursement, the "professional aspects," and quality of care.

*HMO*

Sometimes an IPA member physician will complain that, having made his capital contribution to the venture, he has "not seen the first HMO patient." Obviously, the scope of our MAG IPA activities is much broader than just the delivery of HMO patients to doctors' offices. Many would respond that the doctor's capital contribution was well spent even if he never sees an HMO patient; indeed, many of our member physicians would be just as happy if they never do see an HMO patient.

Nevertheless, GHN does have its own HMO whose role in our venture is twofold: First, it serves as one more activity through which our IPA can influence the direction of the medical marketplace. Second, it will serve as an ongoing source of operating funds for the IPA, thus relieving us from having to reassess the IPA members every year, as is commonplace in many IPAs, including some in Georgia.

Our HMO license was issued in February, 1986, and GHN is still the only HMO in Georgia with a statewide service area. We sold our first account in May, with coverage effective in July, and we now have some 1,600 covered lives under our plan. While this is a respectable showing, it is certainly less than our expectations, and we have moved on several fronts to bolster our marketing program. We have employed a new Marketing Director who has substantial experience, we have redesigned our benefit plans to be more cost-competitive with traditional indemnity insurance, and we have developed a network of brokers to market our product on the broadest possible geographic scale. We feel optimistic, and the 1987 budget and marketing plan show a break-even point of January 1988 — just 23 months from the date we were licensed.

Our initial marketing success has been in middle Georgia, where almost 85% of the practicing physicians are in the MAG IPA. This remarkably high level of participation is a major marketing advantage and explains why our HMO achieved astonishing penetration rates of up to 51 percent among employee groups in the Macon area. We recently penetrated the Atlanta market with two accounts, began marketing in Columbus and Savannah, and renewed our efforts in the "North Georgia Crescent" of Rome, Cartersville, and Gainesville.

***To the extent we have been successful in changing the way these major insurance players perceive the issue of physician reimbursement . . ., we have accomplished a major objective of our venture. . . .***

Long term, there is one marketing issue that is directly controlled by physicians and that will determine the success or failure of our HMO (and perhaps our IPA). Can physicians own and operate a managed care plan that is truly "market driven," as it must be in order to succeed? We have, after all, repudiated some of the cost control measures that others consider central to the success of any HMO, such as gatekeepers, discounts, and capitation. Can we discipline ourselves to control costs when it directly affects our own financial position?

Our early experience with physicians not accustomed to dealing with HMOs suggests that a great part of our task will be to convince Georgia physicians that only by acting together, through the MAG IPA, can we maintain our stability in today's heavy seas of medical economics. "Managed care" is not something we can wish away, but a "managed response" to the volatile situation in which we all practice is possible through our statewide IPA of MAG physicians.

**The Future**

In today's medical economic environment, a 5-year plan makes little sense and a 1-year plan is slightly more than an educated guess. The goal of Georgia Health Network is not to be the only PPO in Georgia or the largest HMO in Georgia. Our goal is to represent the professional and material interests of our member physicians in the changing arena of medical economics.

GHN is the only vehicle that can accomplish what so many of us want — a means for physicians to act together to advance our personal interests and the interests of our patients and our profession.

GHN is a grand experiment. It probably represents the last great opportunity for privately practicing physicians to engage and win the battle for professional control of professional issues. If you are not a GHN member, I invite you to invest in your professional future and join us in this grand venture in medical economics. ■

# Bernard Bragg has won critical acclaim as an actor. He has never heard applause.

PHOTO: ERNESTO BAZAN

Bernard Bragg is a co-founder of The National Theatre of the Deaf. He has performed on television and Broadway and was an artist-in-residence at the Moscow Theatre of Mimicry and Gesture. He has studied under Marcel Marceau and taught workshops at Harvard University.

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# THE HEALTH CARE BUSINESS

KENNETH C. HENDERSON, M.D.

AMONG THE CRITICAL QUESTIONS confronting the medical profession today is not whether society will find ways to govern access to and control the use of medical care, but rather how physicians will participate in the creation of control mechanisms in a manner that reflects both enlightened self-interest and the public trust. Physicians must join with hospitals, educators, and providers to find ways to encourage the general public to understand more about not only their bodies but also the limitations and uncertainties of medical care so that society's decision making can be as fully informed as possible. Only if physicians assume a major role in national decision making can they contribute adequately to the protection of the public interest.

***"Gone are the days of cost-based reimbursement. Prospective pricing has become the order of the day."***

It is essential that the process of decision making be maximally flexible. Many technical approaches to medical care that were acceptable a decade ago are inadequate today. The same must be said about medical, ethical, and moral judgments. Much of what physicians and fellow members of society agree is appropriate now will probably be inadequate for the conditions of the future.

***"How will physicians participate in the creation of control mechanisms to govern access to medical care in a manner that reflects both enlightened self-interest and the public trust?"***

Physicians have always been on the for-profit side of health care. This is how they who are the actual providers make their living and support their families. Doctors continue to provide free medical service, even though some thought 1965 Medicare/Medicaid put an end to indigent care. Medical practice is based on the principle that physicians do everything possible for individual patients. Some believe this concept may be a luxury we can no longer afford. As we develop more and more practices that may be beneficial to the individual but not to the interests of society, physicians risk reaching a point where marginal gains to individuals may threaten the welfare of the whole. Doctors may also need to examine freedom of access to health care and the narrow interpretation of health as an exclusively medical concern. It is not fair to ask the physician to set priorities in the context of his own medical practice.

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A physician must do all that is possible for patients within the limits available. The patient and the physician want no less, and society should settle for no less. However, it is inappropriate to indict physicians for the depletion of resources. An era of difficult ethical issues is fast approaching because of society's inability to fund the increasing cost of health care. These emerging ethical questions mainly deal with the apparent need to ration, or deny, health care at a time when we may be oversupplied with physicians, hospital beds, and services. Only by meeting our professional obligations we can expect or deserve society's reimbursement. Patient care, education, and research produce quality. This should be the standard of care for all. Physicians must not oversell what they can do for patients. This is one way to alleviate the malpractice crisis. Physicians are the best trained, the most responsible, and the only group empowered by society to determine and meet medical care needs. Physicians must act while they still have this cultural obligation and authority. They must accept their leadership role in the medical care system of the future and come forward to redefine and protect their profession for the benefit of all.

***"An era of difficult ethical issues is fast approaching because of society's inability to fund the increasing cost of health care."***

### The Changing Role of Hospitals

In recent years more and more physicians and hospitals have felt the need to operate as businesses. Both find themselves in an environment that seems to demand they leave the non-business world of the church and the university when the majority believe patients should receive medical care regardless of ability to pay. Gone are the days of cost-based reimbursement. Prospective pricing has become the order of the day. Hospitals have gotten so close to their customers that they are not sure if the customer is the physician or the patient. Hospitals have always taken the professional lead from their medical staffs that they should give patients what they need instead of what they think they want. Hospitals may be concerned that physicians have let them down, or more importantly, have lost power and must now resort to the business ethic of giving patients what they think they want. Is hospital management a professional activity or a pure bottom-line endeavor? Hospital managers have been possibly overwhelmed by the pressure to market their product lines due to increasing competition. Some

***"Hospitals have always taken the professional lead from their medical staffs that they should give patients what they need instead of what they think they want. That may be changing."***

have resorted to expanding their public relations department into advertising agencies much to the horror of their marketing consultants and their medical staff. While most have never been convinced that scale economics apply to the health care field, hospitals and physicians have redesigned long range financial plans along those lines. A national shift in hospital quality assurance program to risk assurance is apparent. Risk management was the reactive element of our proactive quality assurance programs. Even though the hospital is now legally responsible for health care, it is an overreaction when the JCAH places medical staff appointments, reappointments, and quality assurance under the risk management heading. Surely, quality assurance depends on the quality of our medical care, not our legal counsel. Do patients really want to have potentially dangerous surgery done in free-standing centers that are away from the support systems of our hospitals? Do mothers want to go home from the hospital after 24 hours if it causes serious health concerns among pediatricians? Certainly, there is some room to move back along the flat part of the cost curve of health care without sacrificing quality. These can be medical decisions, not business decisions.

Well managed, successful hospitals have always made a positive profit margin. The present velocity of change should not cloud vision or wisdom. The hospital need not give up its well earned position as the centerpiece of the health care system and be relegated to the fate of the dinosaur.

### Payors' Concerns

Alternative health care delivery systems seem to surround us. What do they deliver? These financing systems meet the needs of primarily the worried-well. Any manager, professional or not, is able to design a successful system for paying customers. We need systems that address the health needs of 36,000,000 people not covered by health insurance, insurance that will cover all workers as well as workers when they are unemployed, and statewide systems that will fund cross-county indigent care. Is the medical complex able to provide more health care that the people are willing or able to pay for? Are some physicians advancing half-technology at the expense of the common good? Is state-of-the-art medicine used in settings where it cannot be properly studied or researched? Is the cost-benefit ratio of health care being overlooked by physicians, or, more importantly, is the risk-benefit ratio being ignored by patients and physicians? Certainly, payors are beginning to raise meaningful concerns in these areas.

Before turning to several important issues concerning health care in relation to economics, it is useful to dispose of two fallacies that have frequently obstructed clear thinking in this area. The first fallacy is that resources are plentiful. Automation and technology have not put an end to scarcity. Total output always falls short of the amount people would like to have. Time, for example, is the ultimate resource and becomes more valuable the more productive we become. The second fallacy is that health is our most important concern. Many in the health field recognize that physicians and/or hospitals cannot satisfy all wants. However, they believe that health is more important than all other goals of society and that allocation and scarcity are not applicable in this area. It requires only a casual study of human behavior to reveal the fallacy of this position. Everyday people make choices that effect health. It is clear that they frequently place a higher value on satisfying other wants such as smoking, overeating, drinking, substance abuse, careless driving, and even failure to take medication.

Given the scarcity of resources and the existence of competing goals, what is the optimum level of health care utilization? Surely, Americans would not quarrel with the proposition that there is a limit to the resources any society should or can devote to medical care. Few payors would question the suggestion that we are approaching such a limit. Presently, we spend 10.8% of the Gross National Product or $454 billion dollars on health. It has been suggested in 1990 we may spend 11.3% or $640 billion dollars. The resources for medical care are clearly finite, but demands are growing rapidly. It may be possible by the year 2000 to spend 20% of the GNP on health due to our aging population and the availability of donor and electronic organ replacements. How should priorities be set? Who should set them? How much should be allocated? Of that total, how much should be for medical care? How much for research, how much for basic science, and how much for applied science?

***"Even though the hospital is now legally responsible for health care, it is overreaction when the JCAH places medical staff appointments, reappointments, and quality assurance under the risk management heading."***

How much for medical education? How much for educating the public? Who should make these decisions and on what basis should their decisions be made? In the face of conflicts between the interests of the individual patient and society, choices must be made concerning how much of our resources should be spent for kidney dialysis, for babies that weigh less than five hundred grams at birth, for heart transplants and who is eligible. Physicians must join with others, including consumers, if prevention programs are to be maximally effective. It cannot be overemphasized that successes in prevention of disease reflect in large part the fruits of basic science research. Take from education and research and you mortgage the future.

The economic system consists of the network of institutions, laws, and rules created to answer universal economic questions of what goods and services shall be produced, how shall they be produced, and for whom shall they be produced. Health care affects and is affected by the economic system in so many ways as to preclude any attempt at complete enumeration or description. Major emphasis here is to indicate the place of economics in health care, show how related economic concepts can contribute to an understanding of health care problems, and indicate some of the limitations of economics in dealing with such complex area of human activity and concern.

The purpose of cost-benefit ratio is to place a dollar value on various health care inputs. It is clear that preventive medicine and public health produce the most health for the least amount of money. Government and consumers want the greatest benefit for the least cost. Physicians seem to want the greatest benefit regardless of cost. At some point, more money spent may result in less health, thus only benefitting suppliers.

***"Time for example, is the ultimate resource and becomes more valuable the more productive we become."***

The federal government has realized that Medicare is more political than medical. This will be true as long as there is no means test for its use. A non-partisan federal strategy has emerged to get out of the health care field, even though our aging population will demand expansion as opposed to restriction. Employers, insurance companies, and government have shown a strong desire to get out of funding medical education. The dream of one standard of health care for all is a noble concept indeed. We tried to accomplish this with Medicare.

With the winding down of Medicare with DRGs and the financial failure of the Medicaid system, the public is likely to see a three tiered medical system. Politically, the government cannot limit access to care. The first will be government directed or minimal-level care. Who will pay for poor care beyond entry level? The second will be health maintenance organizations or group insurance which will be employer directed. Employers and employees will not want to pay for the uninsured. The third will be private pay, self directed. The question of who will pay for medical education and research remains unanswered. All three systems will have to bear their fair share of responsibility. Industry has an education, research, and development obligation.

Socialistic countries have tried and claim one standard of care for all, or an open-ended medical system. This results in a low standard for everyone, hardly a standard of care we would choose for our country. They have controlled cost by limiting facilities and access, not by designing efficient and effective systems. There must be a better way to control costs than rationing care. Certificate of Need legislation has attempted to control facility expansion but, in too many instances, lawyers have found ways around regulations for their clients. This legislation has lost favor in today's economic climate of deregulations, although hospitals and medical care are not truly a deregulated business. The same federal financial incentives that brought in the entrepreneurial private for-profit sector are now being withdrawn. Patients are more interested in quality than price.

***"It cannot be overemphasized that success in prevention of disease reflect in large part the fruits of basic science research. Take from education and research and you mortgage the future."***

Do physicians have the courage to decide how much should be spent for what? It is implicit they must do this and explicit they must make choices. The only alternative is to go back to a simplier time of the two-tiered system of those that can pay and those that cannot pay. There is no longer such a conservative option. Only a multi-tiered system will be accepted by society. Where do physicians draw the line on cost vs benefit with general public agreement? Do physicians and therefore hospitals ration health care or do they spend a reasonable amount where it will be beneficial? The future has not happened. Physicians must not let others less qualified and

inappropriately motivated manufacture a future for health care that does not put human needs above profit, a profit that they are not likely to return to the health care system. Physicians must involve themselves in medical management as either volunteers or professionals. From the departmental level to the Office of Chief Executive Officer, only physicians are in a position to market quality. They must join other health care professionals in matrix management that will bring to bear all the expertise required to solve our complex problems. They must be in the position to advise other hospital executives on the vast amounts of information and regulation they are bombarded with daily, and work together as partners in the same business, not competitors with different motivation and interests. Otherwise, the casualties of divide and conquer will abound. Tomorrow's technology may help to bring about additional changes, but do not underestimate what is possible to accomplish today nor divert attention and misdirect energies which should be devoted to the complex task of creating a more equitable, effective, and efficient health care delivery system.


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# Hepatitis B in Your Medical Practice: Risks and Recommendations

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Hepatitis B virus (HBV) infects over 200,000,000 people worldwide (1). It is the most important cause of primary liver cancer in the world (1). In the United States, physicians are exposed to HBV far more often than are members of the general public. HBV is the greatest infectious occupational hazard to physicians in the United States (1).

Officials of the United States Centers for Disease Control (CDC) estimate that there are 200,000 new cases of hepatitis B each year in the United States (2). Among infected adults, 6-10% will become infectious carriers of hepatitis B; an even greater percentage of infected children become carriers (2). The current carrier pool in the United States is estimated to be 500,000 to 1,000,000 individuals. This pool grows 2-3% annually. A substantial proportion of new cases each year remain asymptomatic and anicteric; however, patients with such infections are as likely to become carriers as the clinical cases (1,2). Therefore, many carriers of HBV are unaware of the infection they can spread.

There is a safe, effective vaccine against hepatitis B. Heptavax-B, manufactured by Merck, Sharp and Dohme, has been shown to produce protective antibodies in about 95% of healthy adults (2). Over 800,000 physicians and health care workers have already been vaccinated against hepatitis B (1).

Heptavax-B is administered in 3 intramuscular doses. The second dose is given 1 month after the initial dose, and the third dose follows the initial dose by 6 months (2). After over 1,000,000 vaccinations in the U.S. and an equal number abroad, no serious side effects are known to be causally associated with the vaccine (1,2).

### *AT-RISK POPULATIONS*

Only 5% of the general population in the United States shows evidence of past or present hepatitis B infection. However, certain groups are far more likely to contract the infection. Lifetime chance of infection approaches 100% among groups at highest risk.

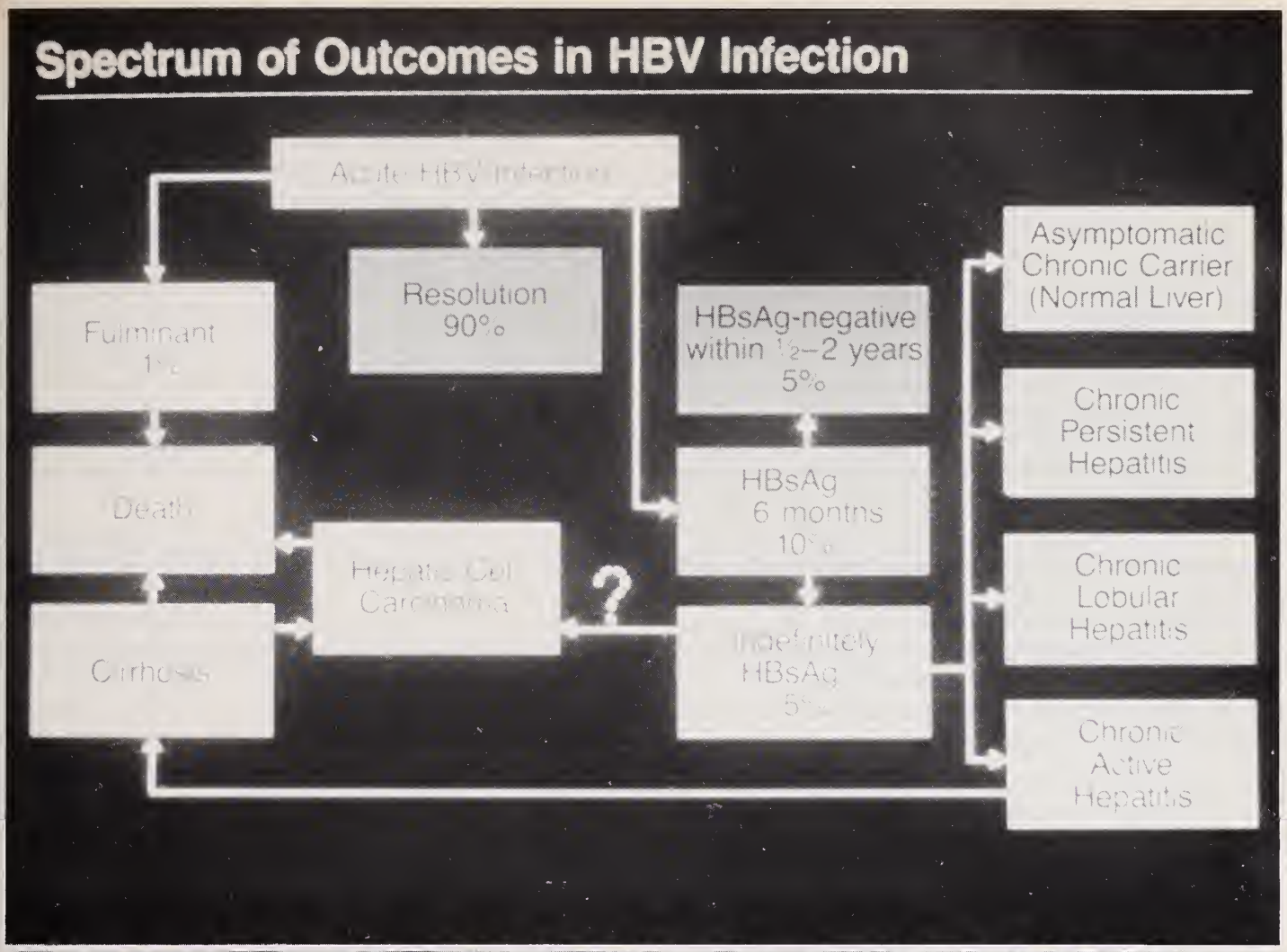
Population groups with above average risk of infection include (2):

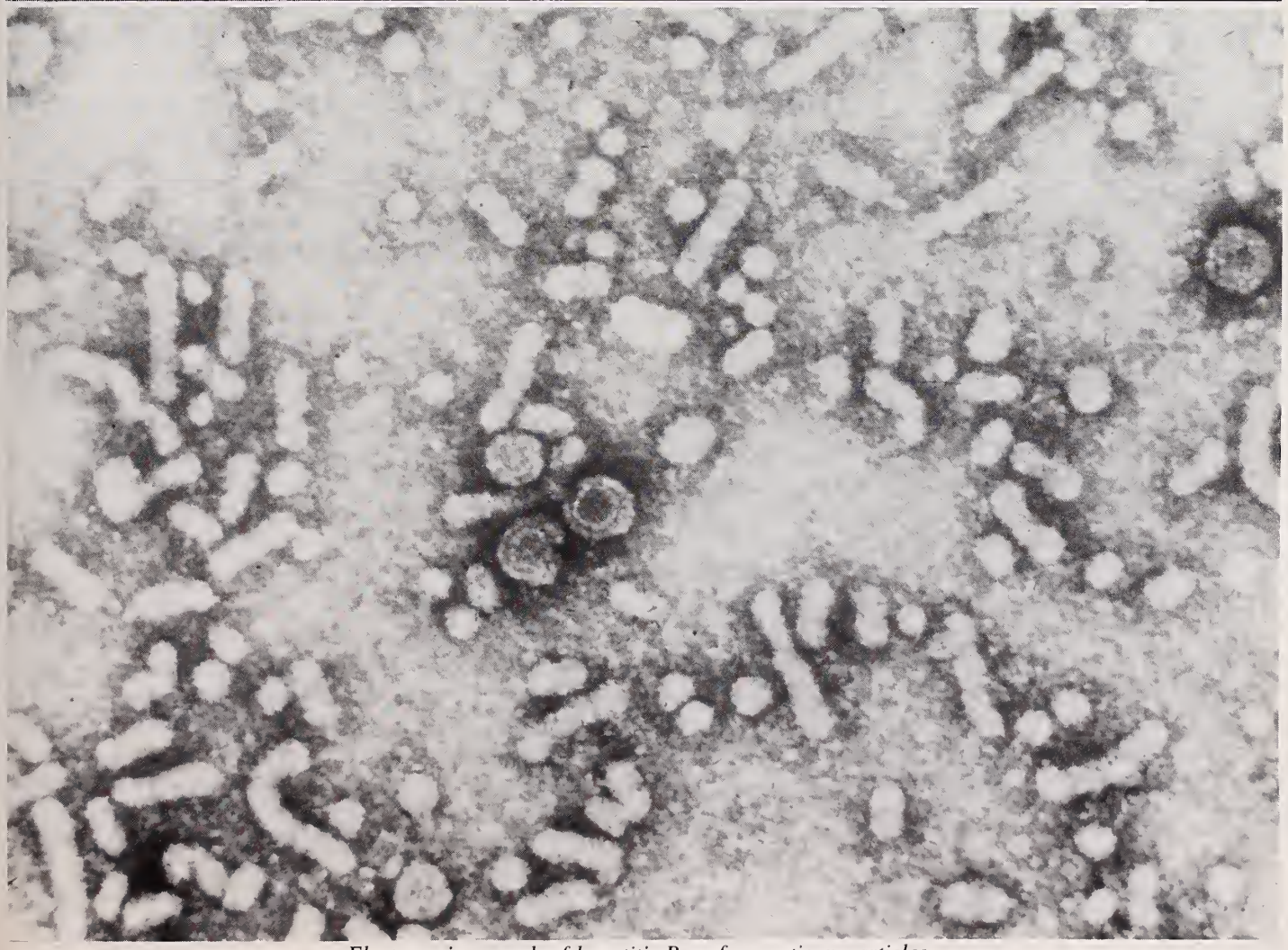
- physicians
- health care workers
- homosexually active men
- heterosexual individuals who have multiple episodes of sexually transmitted disease
- immigrants and refugees from Southeast Asia, sub-Saharan Africa, Amazonia, Haiti, and the Pacific Islands
- Alaskan Eskimos
- clients and staff in institutions for the mentally retarded
- users of illicit, injectable drugs
- household and sexual contacts of HBV carriers
- infants of infectious mothers
- patients of hemodialysis units and hemophiliacs
- male prisoners
- international travelers who may have blood or sexual contact with the population in areas where HBV is endemic

CDC encourages physicians to identify patients who belong to any of these population groups. Staff members who compile patient histories should be alert for patients who may be at increased risk of contracting HBV and should notify physicians immediately. HBV screening and/or vaccination is recommended for individuals in these groups.

### *MODES OF TRANSMISSION*

In recent years, hundreds of thousands of medical personnel, including physicians, have recognized that contracting hepatitis B in the workplace is an unnecessary and unacceptable risk. Their solution has been to receive long-term protection through vaccination. For unvaccinated physicians, the risk is considerable. One nationwide survey concluded that, on average, physicians are over 5 times more likely to have been infected with HBV than are first-time blood donors (3). Another study found that among physicians in some areas of medical practice, HBV markers were 8 times more prevalent than in the



*Electronmicrograph of hepatitis-B surface antigen particles.*

population at large (4). In the course of their careers, at least 1 in 6 physicians will be infected with HBV; in some fields of medicine as many as 50% of physicians may be infected (1,3,4).

Transmission of HBV occurs via percutaneous or permucosal routes. Contact with infective blood is the primary channel of HBV transmission. The more frequent one's exposure to blood, the greater the chance of contracting hepatitis B (4,5). HBV can also be contracted from saliva, semen, and vaginal secretions. Among the general public, contaminated needles and sexual contact frequently spread the disease (2). HBV is not usually transmitted by contact with urine, feces, or other bodily fluids, nor is it transmitted by food or water (2).

Physicians are most frequently contaminated by needle sticks and by blood entering mucous membranes or unnoticed cuts and abrasions. Transmission of HBV is also possible from traces of patient blood which can be found on many environmental surfaces in medical settings. HBV is capable of surviving on such surfaces for at least 1 week (2,4,5,6).

Some physicians are at greater risk than others because they are exposed to more blood, but all physicians with blood contact are at risk and should receive the hepatitis B vaccine. The prevalence of HBV infection among physicians increases with the number of years of practice (3,4).

*POTENTIAL CONSEQUENCES*

The medical consequences of HBV infection vary widely. Approximately one-third of infected adults are asymptomatic, another one-third experience mild, flu-like symptoms, and the remaining one-third exhibit the clinical symptoms of acute hepatitis. These symptoms may include jaundice, anorexia, nausea, vomiting, fever, malaise, extreme fatigue, abdominal pain, rash, joint pain, and dark urine (2).

The human costs of HBV infection are high. As the result of HBV, each year in the United States (2):

- 50,000 patients develop jaundice
- 10,000 people require hospitalization
- 250 people die of fulminant hepatitis

In addition, HBV provides the necessary environment for delta hepatitis, a superinfection or coinfection that replicates only in the presence of HBV. Like HBV, delta hepatitis can have severe short- and long-term consequences. The adverse effects of HBV plus delta infection are more severe than with HBV alone. Up to 12% of patients presenting with delta hepatitis infections die (7,8).

Individuals who contract HBV could be unable to work for as long as several months while the virus runs its course (2,9). Even those who recover from acute HBV infection face possible long-term effects (1,2):

- Cirrhosis: 4,000 individuals die each year from HBV-related cirrhosis.
- Carcinoma: HBV is the single most frequent cause of primary liver cancer; 800 persons die annually from HBV-related hepatocellular carcinoma.
- Carrier state: 6-10% of persons infected with HBV become carriers; 25% of carriers develop chronic hepatitis. Carrier status is associated with as much as a 300-fold increase in the risk of developing liver cancer.

Beyond these medical risks, carriers must remain vigilant throughout their lives against the possibility of infecting others.

Because many physicians develop no clinical symptoms, they may unknowingly fail to protect others, including family members, from infection. In one nationwide survey, 68% of physicians who showed HBV seroconversion had no knowledge of ever having had the disease (3). Such physicians would not have taken precautionary measures during the period they were most infectious.

Physicians who become infected with HBV endanger both their livelihood and their patients. An HBV infection that resulted in permanent infectivity could limit a physician's ability to continue practicing medicine. The medical literature of recent years contains reports of a number of physicians who have infected patients with HBV. Such physicians generally infect several patients before the outbreak is contained. Consider, for example, these cases:

- An obstetrician-gynecologist in Mississippi infected 4 patients during surgeries (10).
- An oral surgeon in California infected 44 patients (11).
- A Dutch heart surgeon infected 3 patients before experiencing the clinical symptoms of HBV infection (12).
- A dentist in Indiana infected 8 patients, 2 of whom died of fulminant hepatitis (13).
- A surgeon in Georgia transmitted HBV to 5 patients without knowledge that he was infectious and, later, to a sixth patient despite double gloving and optimal surgical techniques (14).
- A general practitioner in Switzerland infected 41 of his patients over a 4½-year period (15).
- An oral surgeon in Connecticut transmitted HBV to 12 patients in a 1-year period (16).

The legal ramifications of transmitting HBV could be considerable, particularly if an infected patient were to develop a carrier state or die. Physicians responsible for hepatitis B outbreaks have had to obtain informed-consent waivers from patients (10,14). One such physician, a surgeon, performed 75% fewer procedures in the 6 months following the initiation of the informed-consent procedure (10). Another surgeon was forced to abandon surgery entirely after

infecting a series of patients (14). Because the hepatitis B vaccine is widely regarded as safe and effective, an unvaccinated physician who infected a patient could be exposed to damaging malpractice litigation (17).

In addition to receiving the hepatitis B vaccine and recommending it for at-risk patients, physicians should determine whether their employees are at risk of HBV exposure. Nurses, laboratory technicians, and other medical personnel who handle blood and needles are at high risk of contracting HBV in the workplace (4,6,18,19). If a high-risk employee contracted hepatitis B while at work, the employer could be found negligent in failing to protect at-risk employees from a known occupational health hazard (17,20). Vaccination is becoming standard practice for protection against HBV; therefore, courts are more likely to find that employers are obligated to offer their employees vaccination to protect them from occupational HBV exposure (17,20).

### *POSTEXPOSURE TREATMENT FOR HEPATITIS B*

Vaccination prior to exposure is the only sure way to avoid the danger of HBV infection. Although postexposure vaccination can be effective, it must occur within days following exposure. Because the incubation period of HBV is several weeks to several months, exposed persons may not take action in time to benefit from vaccination.

Immediate measures should be taken to prevent infection if a susceptible person is exposed to HBV. *If postexposure treatment is required, CDC recommends one dose of hepatitis B immune globulin (HBIG) and simultaneous initiation of the hepatitis B vaccination series* (2). Treatment should begin as soon as possible; the value of the treatment is unknown if it is initiated more than 7 days after exposure (2).

Physicians should take particular care to identify expectant mothers belonging to or associated with high-risk populations. Such women should be screened to determine if they are HBV-positive. Untreated newborns of HBV-positive mothers are highly vulnerable to HBV; 60-80% of infected neonates become carriers (2). If untreated at birth, one-quarter of these carrier children will die of hepatocellular carcinoma or cirrhosis (1).

Newborns of HBV-positive mothers should be treated immediately after birth. *In cases of perinatal exposure, administration of hepatitis B immune globulin (HBIG) and the first dose of hepatitis B vaccine should occur on the day of birth.* This regimen has been shown to be 85-90% effective in prevention of the carrier state (2).

### *SCREENING AND VACCINATION*

Certain patients should be screened for HBV antibodies before beginning the inoculation series. Patients who are infected (whether acute or carriers) or who possess antibodies need not be vaccinated; they experience neither salutary nor detrimental effects from vaccination (2).

Screening should be performed on all individuals at high risk (for example, gay men, Southeast Asian immigrants, or intravenous drug users) because it will allow many of these patients to avoid the cost of vaccination. The cost-effectiveness of screening for health-care workers and physicians depends upon how frequently an individual has blood contact. As a worker's exposure to blood increases, so do the chances that screening will reveal immunity, in which case the individual can forego vaccination (2).

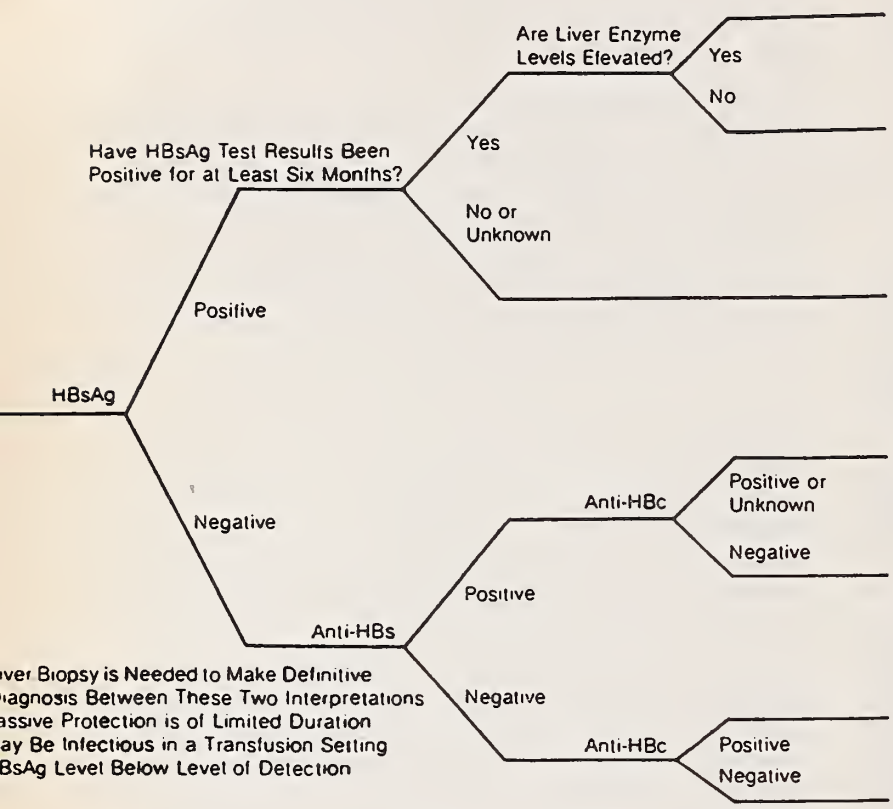
A number of serologic markers are useful for investigating past or present hepatitis B infections in patients. The presence of HBV surface antigen (HBsAg) identifies currently infectious persons; an individual who is HBsAg-negative is not infectious. An individual who is HBsAg-positive at two points in time 6 months apart should be considered a carrier (21).

Detection of antibodies against HBsAg (anti-HBs) indicates that the virus is no longer reproducing; anti-HBs is associated with immunity to further infection. Antibodies to the core antigen (anti-HBc) are present throughout the period of acute infection and can sometimes be detected for life. Anti-HBc is the best indicator of infection at any time in the past (1,2,21). The chart on the following page summarizes the relationship between HBV infection and serologic markers (22).

### *A SERIOUS PROBLEM—A SIMPLE SOLUTION*

Hepatitis B is a highly infectious disease with potentially serious medical consequences. Physicians and other medical personnel are exposed to HBV far more often than are members of the general public. Because a large proportion of all cases of hepatitis B are subclinical, physicians run a considerable risk of carrying an infection without their knowledge and, in turn, of infecting family members or patients. Furthermore, only HBV vaccination can protect physicians against the possible legal and financial risks arising from transmitting HBV infections in medical settings. Certain populations within the general public are also at high risk. Physicians and their patient-care personnel should be alert for patients with high-risk profiles and should encourage immediate screening/vaccination against HBV.

There is a safe, simple alternative to the potential disasters of HBV infection: *hepatitis B vaccination.* In light of costs and benefits of HBV vaccination, physicians, their at-risk employees, and at-risk patients should be vaccinated against HBV as soon as possible.




| Interpretation | Immune to Further HBV Infection | Poten Infect to Ot for H |
|---|---|---|
| Chronic Persistent Hepatitis, or, | Yes | Ye |
| Chronic Active Hepatitis* | Yes | Ye |
| Chronic Carrier of HBV (Asymptomatic) | Yes | Ye |
| Acute HBV Infection, or, | Yes | Ye |
| Chronic Carrier of HBV | Yes | Ye |
| Normal Immune Response to Previous HBV Infection | Yes | No |
| Response to Immunization With HBV Vaccine, or, | Yes | No |
| Passive Immunity after HBIG Vacination, or, | Yes/No† | No |
| Normal Immune Response to Previous HBV Infection, Many Years Later | Yes | No |
| "Window-Phase" Convalescence of HBV Infection, or, | Yes | No |
| "Low-Level Carrier" in Nonacute Setting‡ | Yes | No/Ye |
| No Evidence of HBV Infection | No | No |

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a better time for her..
and
PREMARIN®
(Conjugated Estrogens Tablets)

# Now the evidence looks better than ever

## Significantly reduced risk of endometrial hyperplasia

Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month.[1-4] The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

## Effect on lipids—an important feature

PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.[5]

## Low-dose control of menopausal symptoms*

PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

## The most widely used, most extensively studied estrogen worldwide.

# PREMARIN®

(Conjugated Estrogens Tablets)

## Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

# For moderate-to-severe vasomotor symptoms

# PREMARIN®
## (Conjugated Estrogens Tablets)

0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

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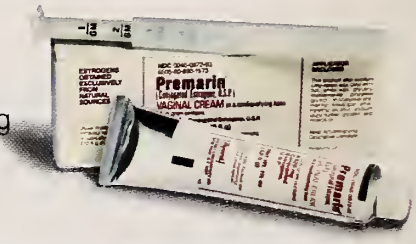
# For atrophic vaginitis

# PREMARIN®
## (Conjugated Estrogens)

Vaginal Cream

0.625mg/g




BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

**PREMARIN® Brand of conjugated estrogens tablets, USP**
**PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base**

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA.

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.
2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.
The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

**DESCRIPTION:** PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

**INDICATIONS AND USAGE:** PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

**Concomitant Progestin Use:** The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

**CONTRAINDICATIONS:** Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

**WARNINGS:** Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

**PRECAUTIONS:** Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.
b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.
c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.
d. Impaired glucose tolerance.
e. Decreased pregnanediol excretion.
f. Reduced response to metyrapone test.
g. Reduced serum folate concentration.
h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

**ADVERSE REACTIONS:** The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

**ACUTE OVERDOSAGE:** May cause nausea, and withdrawal bleeding may occur in females.

**DOSAGE AND ADMINISTRATION:**

**PREMARIN® Brand of conjugated estrogens tablets, USP**

1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.
2. *Given cyclically:* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis —0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

**PREMARIN® Brand of conjugated estrogens Vaginal Cream**

*Given cyclically for short-term use only.* For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

**References:**

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# Tort Reform in 1987

## A Significant Improvement

*Richard Greene*

***"With the passage of the tort reform bills, the 1987 Georgia General Assembly took a significant step forward in solving some of the judicial and insurance problems facing physicians."***

THE 1987 GEORGIA GENERAL ASSEMBLY took a significant step forward in solving some of the judicial and liability problems facing physicians. This was accomplished by the Georgia Legislature recently passing two major bills dealing with the general subject of "Tort Reform." Several other related bills also were enacted. A legal analysis clearly indicates vast improvements over the present law.

Based more on political posturing than legal necessity, the "Medical Malpractice Reform Act of 1987" was enacted through Senate Bill 2; and the "Tort Reform Act of 1987" was found in House Bill 1. The two combined bills consisted of eight of ten major reforms sought this year by the MAG. The eight reforms included:

(1) reduced statute of limitations for minors;
(2) pre-filing affidavits;
(3) limited immunity for some free medical care;
(4) $250,000 cap and modification of punitive damages awards;
(5) disclosure to the jury of "collateral sources" of compensation;
(6) judicial modification of jury verdicts;
(7) modification of the "joint and several" liability rule;
(8) immunity for directors, trustees, members, and uncompensated officers of some non-profit organizations.

A third important but less far reaching bill was introduced during the middle of the Session and was also enacted into law. House Bill 75 provides tort immunity for medical students. Their insurance costs would have skyrocketed from approximately $50.00 per year to $1,800 within the next 5 years. To address this problem, the General Assembly granted medical students immunity from suit when acting in the course of their training under faculty supervision. The liability flows to the faculty member unless the student is guilty of wilfull or wanton misconduct.

### Background

Thanks to the leadership of Lt. Governor Zell Miller, the original version of Senate Bill 1 was offered in late summer prior to the January convening of the Legislature. This version of Senate Bill 1 included a $250,000 cap on pain and suffering.

Senator Greene is MAG's General Counsel.

Considerable political jockeying prior o the General Assembly convening ed to the exclusion of this ninth, yet ital reform. Lt. Governor Miller had ver 40 Senators who agreed to co-ponsor this pro-medicine legislation hich included all nine reforms.

Regrettably, inadequate support as coming from other members of he Legislature and considerable pposition was emerging from arious sources, such as the Georgia rial Lawyers Association and even ome print and broadcast media. However, without the dynamic and arly leadership exhibited by Lt. Governor Miller, it is doubtful hether the comprehensive package f reforms that actually passed would ave made it through the complex egislative process. His strong osition forced others to join or be eft behind.

LATE SUMMER AND fall found Governor Joe Frank Harris' Commission on tort reform actively eceiving testimony from various nterested groups and individuals. Both Governor Harris' Commission which was dominated by trial ttorneys) and Governor Harris, imself, failed to support a cap on ain and suffering. Additionally, the Governor's Commission, along with MAG Mutual Insurance Company and the St. Paul, recognized the benefits of structured settlements, but each requested that that tenth reform item be eliminated from consideration in 1987. The Governor's Commission and MAG Mutual Insurance Company are seeking further study of the best way to implement this highly technical legal concept. St. Paul, on the other hand, supports the concept of structured settlements, but prefers that they not be mandated into law.

By a vote of 48 to 2 in the Senate and 149 to 14 in the House of Representatives, the General Assembly on February 20, 1987, passed Senate Bill 2, known as the "Medical Malpractice Reform Act of 1987." It contains the three major provisions of (1) statute of limitation for minors, (2) pre-filing affidavits, and (3) limited immunity for some non-compensated medical care.

### Statute of Limitation for Minors

A major contribution to the high cost of medical malpractice insurance is the long "tail" found in many claims or potential claims for minors. Under present law, a minor or legal incompetent cannot be required to bring an action against a physician until 2 years after the minor becomes an adult at age 18, or when the legal disability of incompetence is removed. Therefore, a lawsuit for an injury at birth will not have to filed by the plaintiff until the day before his twentieth birthday. To remedy this problem, the 2-year statute of limitation was changed in Senate Bill 2 to begin running at age 5 if the injury or discovery of the injury occurred prior to the child's fifth birthday. If an injury or its discovery occurred any time from birth to age 5, the lawsuit would have to be filed by the child's seventh birthday. A minor or incompetent who is injured after age 5 will have 2 years from the injury or discovery of the injury in which to bring the action in court.

THE RULE of "discovery" of the injury has also created a complicated legal problem. The former law in Georgia held that the statute of limitation began running at the time of the "occurrence." This meant that a person had 2 years to file a lawsuit from the time of treatment even though the person was not injured until later. The Supreme Court of Georgia struck down the statute and instituted the so-called "discovery"

rule in a case involving a woman who had an allegedly negligent tubal ligation performed.[1] She "discovered" that she was pregnant a little over two years after the surgery was performed. The Supreme Court ruled that a statute of limitation based on "occurrence" was unconstitutional for violating the equal protection clause, and

> ***"A minor or incompetent who is injured after age 5 will have 2 years from the injury or discovery of the injury in which to bring the action in court."***

thereafter installed by case law the "discovery" rule. Although this may sound reasonable; however, its application theoretically means that a physician who performs a procedure or treatment could be liable for an injury "discovered" at any time in the future until 2 years after the patient's death. To address the problem, the General Assembly in 1983 enacted a 5-year "statute of repose."[2] This means that a patient's right to bring a lawsuit is abrogated 5 years after the "occurrence," regardless of whether or not the injury has been "discovered." The Medical Malpractice Reform Act of 1987 incorporated the 5-year statute of repose to also apply to minors and incompetents beginning at age 5.[3] Therefore, when a patient's injury was not "discovered" until after age 5 and when the treatment or "occurrence" was prior to age 5, then the new repose statute will mean that the lawsuit will have to be filed by the patient's tenth birthday rather than the present case law which allows up to the patient's 23rd birthday.

This new provision of a 2-year statute of limitation and a 5-year statute of repose could eventually lead to an improved insurance premium climate. It must be pointed out, however, that even though the Supreme Courts of three states have upheld similar statutes,[4] there are at least seven courts that have held their state's statute to be unconstitutional. It is possible that it may be up to ten years before we will know how the Supreme Court of Georgia will rule on this particular issue. Ohio passed a similar act in 1976 as part of a tort reform package. It was finally declared unconstitutional by the Supreme Court of Ohio in December, 1986. This lengthy process occurs because there probably will not be a minor barred from bringing an action under the new statute of limitation until after July 1, 1989. Add a few years of litigation, and Georgia, too, is several years away from a legal answer, and, therefore, some time away from improved insurance rates as a direct result of this particular section of tort reform.

### Pre-filing Affidavit

The second section of the Medical Malpractice Reform Act of 1987 is, in the opinion of several defense attorneys and insurance personnel, perhaps the most important part of tort reform. This new provision should substantially eliminate the filing of actual "frivolous" lawsuits. Prior to filing a medical malpractice lawsuit against a physician, the patient's attorney will be required to have a medical expert review the medical records of the case and sign a sworn affidavit stating that in their professional opinion "at least one negligent act or omission claimed actually exists and the factual basis for such a claim."[5] This would be done at the plaintiff's expense. This, hopefully, will practically eliminate some inexperienced attorneys from filing groundless lawsuits because adequate investigation was not conducted prior to the filing of the pleadings.

There is one exception to the pre-filing requirement. Without extendin the statute of limitation, this new ac provides an extension for the filing of the expert's affidavit in cases where the lawsuit is filed within 10 days of the expiration of the statute of limitation. In these cases, the lawsuit can be filed, and the plaintiff's attorney has 45 days to supplement his pleadings with the expert's affidavit. However, in these limited cases, the new statute also extends the time required for the defense to file an answer until 30 days after the affidavit is filed. Conceivably, if the affidavit was not obtained, the case could be dismisse without the physician ever having to file an answer to the groundless suit Also, because of other statutes and case law, it is now easier to file a countersuit for damages against the plaintiff and his or her attorney for their having filed an unfounded lawsuit.

### Good Samaritan Extension

A provision of the new act[6] that was much talked about, often misunderstood, and perhaps intentionally misrepresented by some media was dubbed an extension of the present "Good Samaritan" act.[7] This new provision provides physicians, dentists, optometrists, and nurses with limited immunity when certain charity care is provide This section was opposed by some indigent groups, a few vocal physicians, and the trial lawyers. It was not part of MAG's original package of tort reform proposals. Its origin was found in the Governor's Commission on tort reform from a request submitted by the Georgia

ate Medical Association. Their rpose was to encourage and to sure the *availability* of medical re to those who could least afford With physicians being sued at ery turn, even by patients who ceive free medical care through a arity sponsored clinic, the greater ue rapidly becomes the issue of vailability'' of care. There were o awards in Georgia this past year ainst physicians who volunteered ir time to give health screening to al athletic teams. The real jury ue in that type of case is not ault'' but rather ''compensation'' minors.

This section started out applying to health care providers but was later ited to persons licensed under the ards dealing with dentists, nurses, tometrists, and physicians. Also cluded are ''licensed hospitals, blic schools, nonprofit ganizations'' and ''agencies of the te or one of its political

***''A provision of the ew act that was much lked about, often isunderstood, and erhaps intentionally isrepresented by some edia was dubbed an tension of the present Good Samaritan' t.''***

ubdivisions'' which ''requests, ponsors, or participates in the roviding of services'' that are rovided ''voluntarily and without e expectation of receipt of ompensation.''[8] The professional ervice rendered must also be within e professional's scope of licensure, as well as, for and at the request of one of the above organizations. That organization likewise must not receive compensation for the services provided from or on behalf of the recipient. A practical application would be for a non-profit organization to sponsor a free health clinic and request that a physician give assistance. Under this new statute, the physician and the organization could still be sued; however, the standard for the jury to consider would not be mere ordinary negligence, but rather ''gross negligence or willful or wanton misconduct.''[9]

Even though this section does not provide total immunity, it does provide more protection than is now available. It is hoped that it will encourage more pure charity care for Georgia's citizens. It does not, nor should it, establish a secondary level of care for the poor. If a physician contemplates providing poor care because a person is indigent, then that physician is probably guilty of ''willful and wanton misconduct'' and therefore would likely be liable for any acts of negligence.

### Cap on Punitive Damages

House Bill 1, which is titled the ''Tort Reform Act of 1987'' contains the remaining five reform proposals. The most complex and innovative reform is found in the section dealing with punitive damages. Punitive damages by definition are to punish the defendant for the act committed. They do not include other types of damages that compensate the plaintiff for his or her losses (i.e., medical expenses, damaged property, lost wages, pain and suffering, etc.).

A major political psychologic barrier was breached with the placing of a $250,000 dollar ''cap'' on most punitive damage awards. They were also made more difficult to prove by requiring a plaintiff to prove his or her case ''by clear and convincing evidence,'' rather than a mere preponderance of the evidence. The plaintiff must also show that the defendant's acts or omissions were so willful or fraudulent as to ''raise the presumption of conscious indifference to the consequences.''[10]

There are additional technical and legal requirements as well as a new form of trial for punitive damages. After hearing evidence of the main case, the jury, during its deliberations, will also answer a question posed by the court as to whether or not the jury feels that punitive damages should be awarded. If the response is positive, then a new phase of the trial will begin with evidence being presented on the issue of how much money, if any, should be awarded. Thus, there are two phases to the trial and two separate deliberations by the jury.

In most punitive damage cases in which a physician might be liable, the jury will be limited to an award not to exceed $250,000. An exception is cases involving products liability. Those cases will not contain a cap on the amount awarded; however, the defendant can be found liable for punitive damages in only one case even though other persons were also injured by the same product. A significant new wrinkle in the law will also mean that whatever amount is awarded by the jury for punitive damages in a products liability case, the amount will be divided so that the state will receive 75% of the award and the plaintiff 25% after attorneys fees and expenses of litigation have first been paid. The fees and expenses portion is a major flaw in this particular section, because the attorney will potentially end up with more money than the client.

### Collateral Sources

A section of substantial value to both the business community and

medicine involves the disclosure to the jury of "collateral sources" of compensation available to the plaintiff. Under today's tort system, the jury is usually not told that the plaintiff's medical expenses have already been paid by insurance, that their lost wages have been covered, that their damaged property restored, and that other types of insurance coverages and compensations are available to the plaintiff. Sometimes a plaintiff will be reimbursed for the same expense by three or four insurance companies, plus by a jury. This new statute requires that collateral sources of compensation be disclosed to the jury, and they may take it into consideration when reaching a verdict. Now the jury will have a truer picture of the actual losses incurred by the plaintiff. Some insurance analysts feel that this section has the potential for substantially reducing the amounts paid out by the carriers. Some analysts contend that this is the single most important section in the tort reform package.

### Judicial Modification of Jury Awards

One of the problems experienced across the nation in medical malpractice and other liability cases are the so-called "excessive" verdicts. Likewise, some verdicts are equally inadequate for the injury received. This new section will expand the power of the judge to order a new trial as to damages only after determining that the verdict was too high or low so as to be "inconsistent with the preponderance of the evidence in the case." The judge can also suggest to the parties that a particular amount is appropriate and order a new trial if one of the parties refuses to accept. Only one such new trial on damages can be ordered.

### Joint and Several Liability

The section on joint and several liability was the most controversial, the most opposed by the Georgia Trial Lawyers Association, and the most wanted by the business community of the eight proposals. Joint and several liability refers to the rule that if you are one of several defendants in a lawsuit where the jury finds against the defendants, then all of the defendants are equally liable for all of the damages. Thus, it matters not if a defendant is 1% liable or 99% liable, each will share equally. In many cases, however, one defendant has nothing and another has "deep pockets" through assets or insurance. In those cases the deep pockets defendant may have been 1% liable, but pay 100% of the verdict. Under this new section, if the jury finds that the plaintiff is to some degree also responsible for the injury or damages, then the jury has the option to apportion its award among the defendants according to the "degree of fault" of each defendant. For example, the jury could determine damages at $100,000 and that the plaintiff was 10% liable, defendant A (Mr. Deep Pockets) 50% liable and defendant B ( Mr. No Pockets) 40% liable. Therefore, defendant A would pay $50,000 and defendant B $40,000. Under present law, Mr. Deep Pockets could have been forced to pay the entire $100,000. This does not abolish joint and several liability, but it does substantially modify the doctrine.

### Immunity for Non-Profit Members and Directors

The final section to be covered is very important to society as a whole. It provides protection from lawsuits for members, directors, trustees (both compensated and uncompensated) and for uncompensated officers of the board of a "non-profit hospital or association or of any nonprofit, charitable, or eleemosynary institution or organization or of any local governmental agency, board, authority, or entity."[11] Reimbursement for reasonable, related expenses is not considered compensation.

As government realizes that it cannot afford to solve all of society's problems, it has encouraged participation by and expansion of charitable functions. To encourage charity workers, this section makes the members, directors, trustees and unpaid officers immune from civil liability if the act or omission was done in "good faith" and it was done within the scope of the official's duties and was not done in a "willful or wanton" manner. This section does not presently apply to "volunteers" who are not also "members" of an organization, so if you volunteer to help a charity in order to receive this grant of immunity, remember to join as well. If you march for dimes or dollars, join the organization first if you think that you might be sued. Despite some shortcomings, this section is very important to literally thousands of non-profit organizations such as MAG, Big Brothers, Special Olympics, etc. and their members who have been serving worthy causes at great legal risks.

### Conclusions

The eight major reforms found in the Medical Malpractice Reform Act of 1987 and the Tort Reform Act of 1987 are not perfect, but they do constitute a substantial step in the right direction. It is anticipated that each of these eight sections will be litigated for many years to come. They will not lead to an immediate lowering of insurance premiums, but hopefully they will help stabilize the present trend toward higher rates. They are a significant beginning, not an end. Political expediency will likely dictate that another major push for further reforms abate for now; however, other related issues are being vigorously pursued. The physicians of Georgia should be proud of their legislative accomplishments and of the leadership they exhibited on this issue. Excellent improvements have been made to the laws that impact the filing, trial, and results of lawsuits.

### Notes

1. Shessel v. Stroup 253 GA. 56, 316 S.E. 2d155 (1984)
2. O.C.G.A. 9-3-71
3. O.C.G.A. 9-3-90
4. Alabama, California, Indiana
5. The Medical Malpractice Reform Act of 1987
6. O.C.G.A. 51-1-29.1
7. O.C.G.A. 51-1-29
8. The Medical Malpractice Reform Act of 1987
9. The Medical Malpractice Reform Act of 1987
10. The Tort Reform Act of 1987
11. The Tort Reform Act of 1987 and as amended by S.B. 113.

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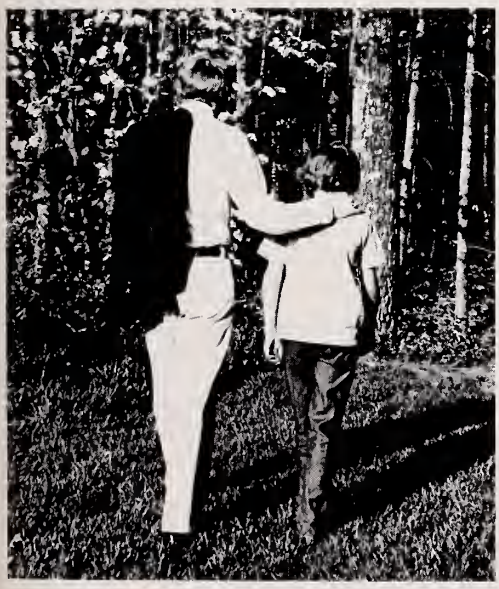

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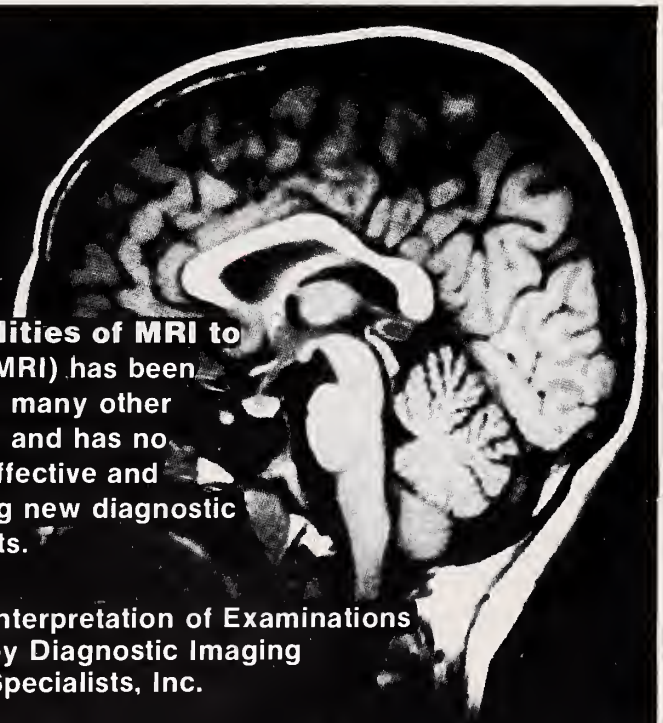

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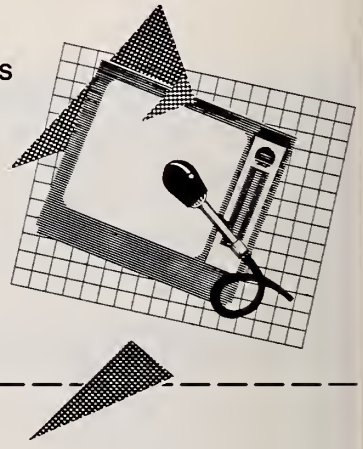

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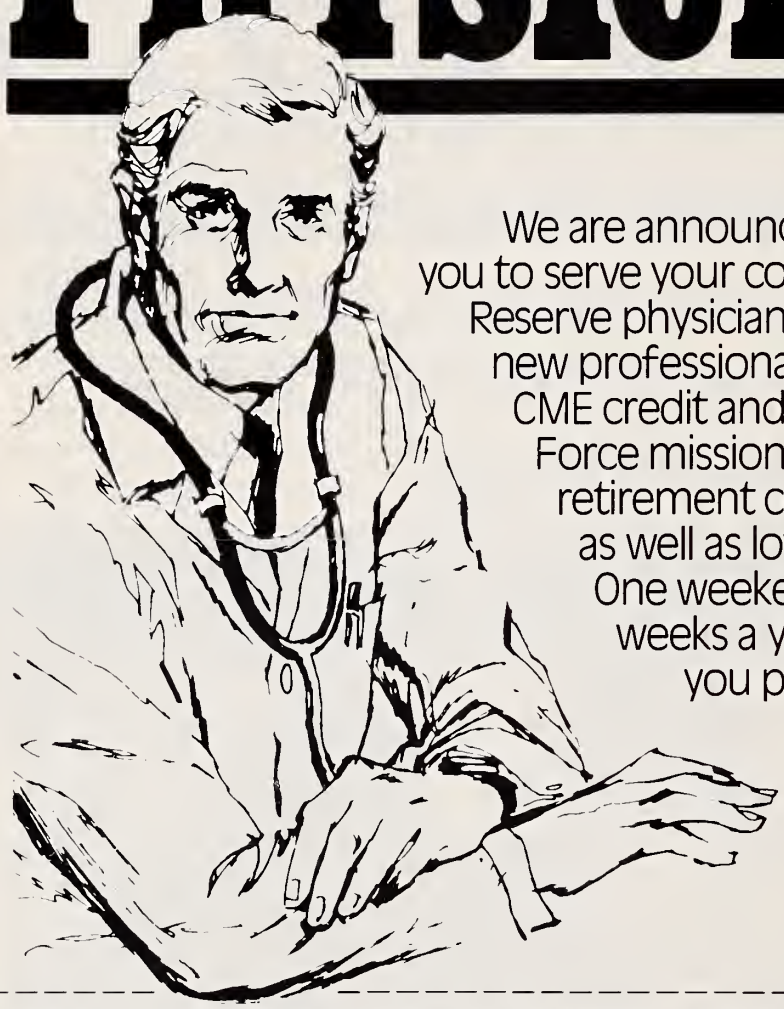

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# A Case of "Torsade de Pointes"

## An Unusual Ventricular Arrhythmia

*Charles E. Drake, M.D.*

*"Torsade de pointes, ich is a subvariety of lymorphic ventricular chycardia, is always aracterized by a olongation of the QT terval during sinus ythm."*

THE FOLLOWING CASE illustrates many of the classical features of the unusual ventricular arrhythmia, "Les Torsade de Pointes." First described in the French literature in 1966, the original name means "twisting of the points,"[1] Because the treatment of this arrhythmia is unique, recognition is essential. The typical ECG in torsade de pointes shows runs of rapid ventricular tachycardia, with wide QRS complexes of varying rate which display progressive changes in amplitude and polarity such that they appear to be twisting around an isoelectric baseline.

Generally, ventricular tachycardia can be divided into two classes: the monomorphic and the polymorphic. Monomorphic ventricular tachycardia is uniform and regular in appearance. Polymorphic ventricular tachycardia is pleomorphic in nature and in most cases has the same clinical significance as monomorphic ventricular tachycardia. Torsade de pointes, which is a subvariety of polymorphic ventricular tachycardia, is always characterized by a prolongation of the QT interval during sinus rhythm.[2] Torsade is associated with various underlying causes of QT prolongation, such as hypokalemia and anti-arrhythmic treatment with Type IA anti-arrhythmic drugs (quinidine, procainamide, disopyramide).[3] The electrocardiogram in torsade de pointes demonstrates a typical "long-short" initiation sequence in which a ventricular beat is followed by a compensatory pause and next by a beat of supraventricular origin. The next beat is a ventricular beat demonstrating R-on-T phenomenon with initiation of the tachycardia.[4] Postulated electrophysiologic mechanisms for the arrhythmia include reentry and abnormal afterdepolarizations.[5]

Dr. Drake practices internal medicine/cardiology. Send reprint requests to him at 5354 Reynolds St., Ste. 204, Savannah, GA 31405.

This paper was sponsored by the Georgia Affiliate of the American Heart Association. Others wishing to contribute papers to this Section should contact Wesley Covitz, M.D., HEART Section Editor, and Professor of Pediatrics, Section of Pediatric Cardiology, Medical College of Georgia, Augusta, GA 30912.

### Case Report

A 24-year-old woman with a history of drug abuse presented with a seizure and the rapid development of coma. The right pupil was fixed

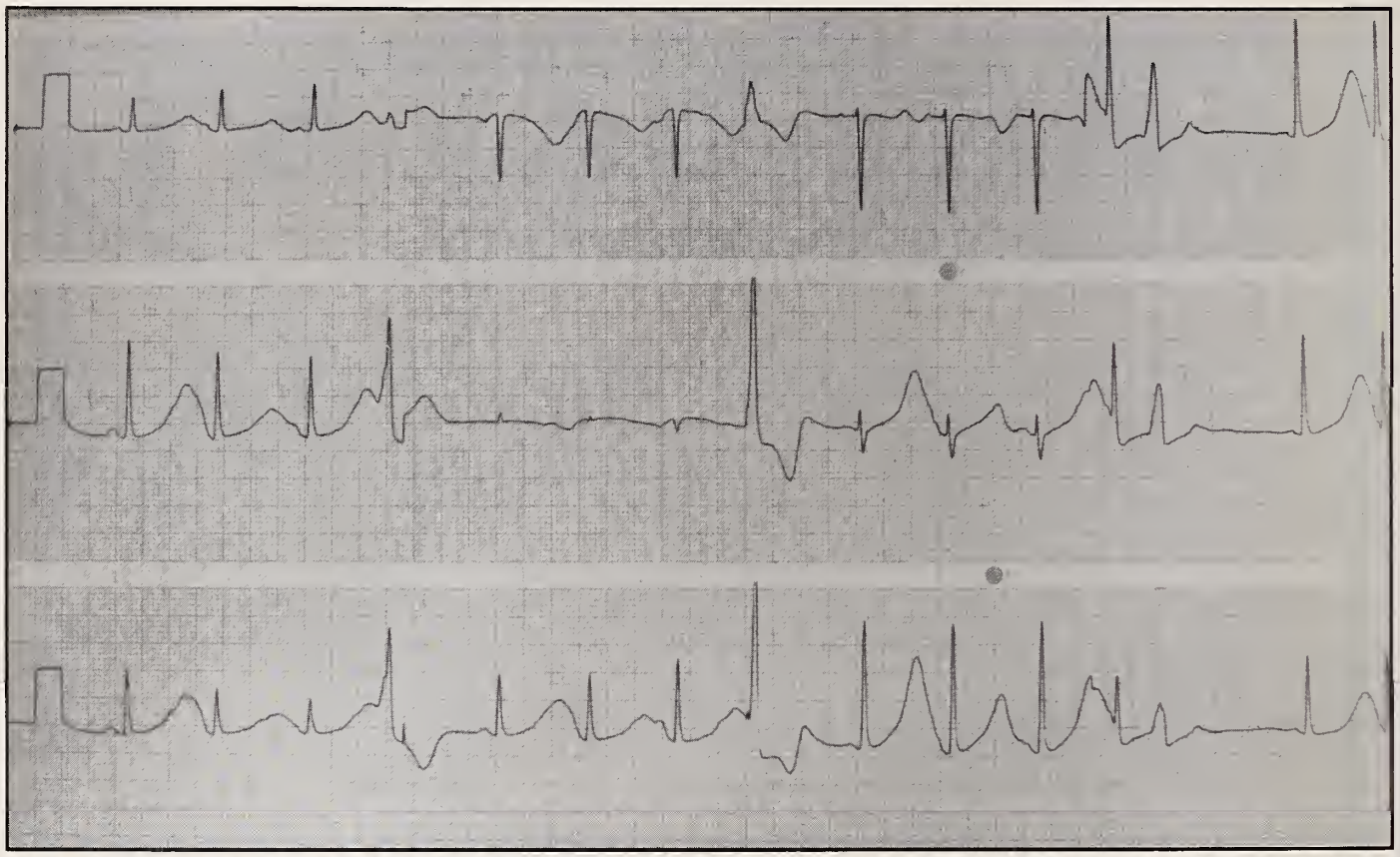

*Figure 1 — Electrocardiogram taken during periods of sinus rhythm demonstrated marked QT interval prolongation of approximately 560 msec.*

and dilated. A computerized axial tomographic scan of the brain demonstrated a large subdural hematoma on the right, with a right-to-left shift of intracranial contents. There was no obvious evidence of head trauma. Her medical history was negative for prior episodes of syncope. There was no family history of cardiac disease. Prior electrocardiograms were not available initially, but were located later and demonstrated normal sinus rhythm with only minimal ST-T changes and no QT prolongation.

After admission to the hospital, the patient underwent an immediate craniotomy with evacuation of the hematoma. In the initial post-operative period, she experienced numerous episodes of ventricular tachycardia and ventricular fibrillation. Her electrocardiogram taken during periods of sinus rhythm demonstrated marked QT interval prolongation of approximately 560 msec (Figure 1). There were frequent and multiformed premature ventricular beats. The electrocardiogram during periods of tachycardia demonstrates polymorphic ventricular tachycardia (Figure 2). The patient had failed to respond to intravenous lidocaine and had required cardioversion and intermittent cardiopulmonary resuscitation.

As soon as the nature of the arrhythmia was recognized, lidocaine was discontinued and an isoproterenol drip was titrated to maintain the heart rate at about 110 bpm. This extinguished further ventricular arrhythmia. Serum potassium was measured at 2.7 mEq/l. After replacement of potassium and after 24 hours, the isoproterenol drip was successfully weaned. The QT interval gradually returned to normal by the fourth post-operative day. She improved neurologically and appeared to have no permanent neurologic impairment. Twenty-four hour continuous ambulatory monitoring prior to discharge showe no evidence of arrhythmia. A two-dimensional echocardiogram was normal. She was discharged on no anti-arrhythmic therapy.

## Discussion

Potential causes for the arrhythmi "les torsade de pointes" are essentially those of QT prolongation In this patient, they included hypokalemia, head injury, and possible congenital QT prolongation Slow resolution of the ECG changes raised this last possibility, but when old electrocardiograms were located this diagnosis was excluded. Long QT syndrome may be inherited as a autosomal recessive with associated congenital deafness. Individuals with this syndrome are prone to life-threatening ventricular arrhythmias and frequent episodes of syncope. Types of treatment that have been advocated include left stellate ganglionectomy and beta blocker therapy.[7]

*Figure 2 — The electrocardiogram during periods of tachycardia demonstrates polymorphic ventricular tachycardia.*

The secondary causes of QT interval prolongation are much more commonly encountered. These include drug effects, cardiovascular disorders such as myocarditis or myocardial ischemia, electrolyte disturbances, and central nervous system events.

DRUG-INDUCED QT interval prolongation has been described with a number of agents including Type IA anti-arrhythmic agents (quinidine, procainamide, disopyramide), the tricyclic anti-depressants, and phenothiazines. Torsade de pointes has occurred not only with toxic levels of antiarrhythmic agents but also as an idiosyncratic reaction. There have been descriptions of the arrhythmia occurring after administration of mexiletine, flecanide, encainide, amiodarone, and sotalol. All of the agents which have been documented to produce torsade de pointes are known to prolong the QT interval, although there are numerous anecdotal reports with other drugs.[6]

The most common electrolyte disturbances associated with QT prolongation are hypokalemia and hypomagnesemia. The condition has been described with the liquid-protein diet.

The goal of therapy is to remove the predisposing causes as much as possible and then suppress the arrhythmia. The offending agent(s) must be completely withdrawn, and any electrolyte abnormality should be corrected. Electrical defibrillation has only limited usefulness, since the arrhythmia will likely continue to recur. Atrial or ventricular overdrive pacing is the primary means of emergency treatment. An isoproterenol infusion may be beneficial as temporary treatment, although it is contraindicated in the congenital long QT syndrome, hypertensive patients, or in patients with coronary artery disease. Magnesium sulfate, bretylium, and lidocaine, as well as beta blockade, have been reported to be useful upon occasion.

If congenital long QT syndrome is diagnosed, then the patient should be considered for long-term beta blocker therapy, surgical sympathectomy, or chronic overdrive pacing.

AN IMPORTANT caveat is that certain commonly used anti-arrhythmic agents are not only ineffective but actually harmful. Unless the arrhythmia is recognized, the clinician may tend to increase the level of treatment with drugs which only worsen the patient's condition.

***"An important caveat that certain commonly used antiarrhythmic agents are not only ineffective but actually harmful."***

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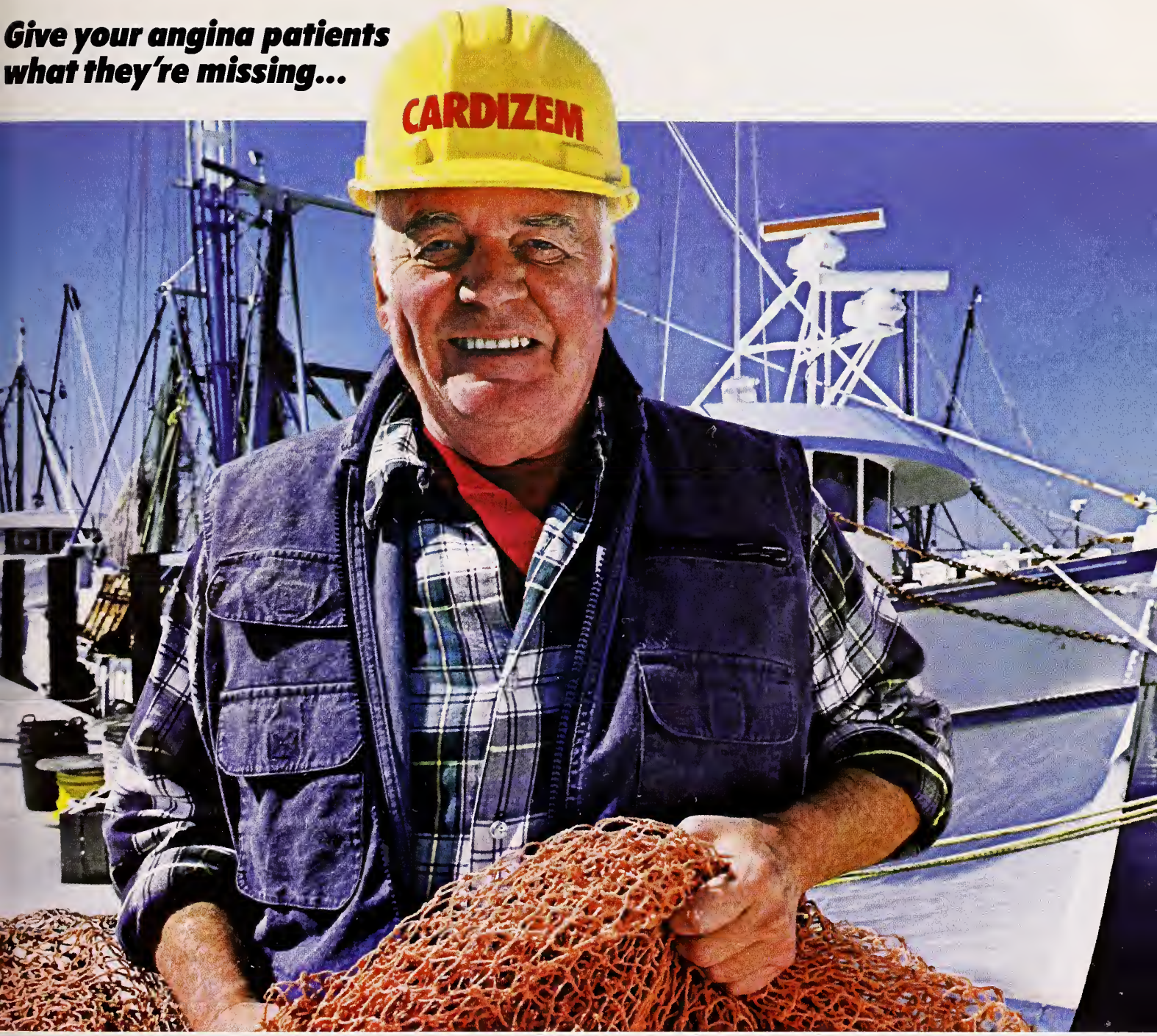


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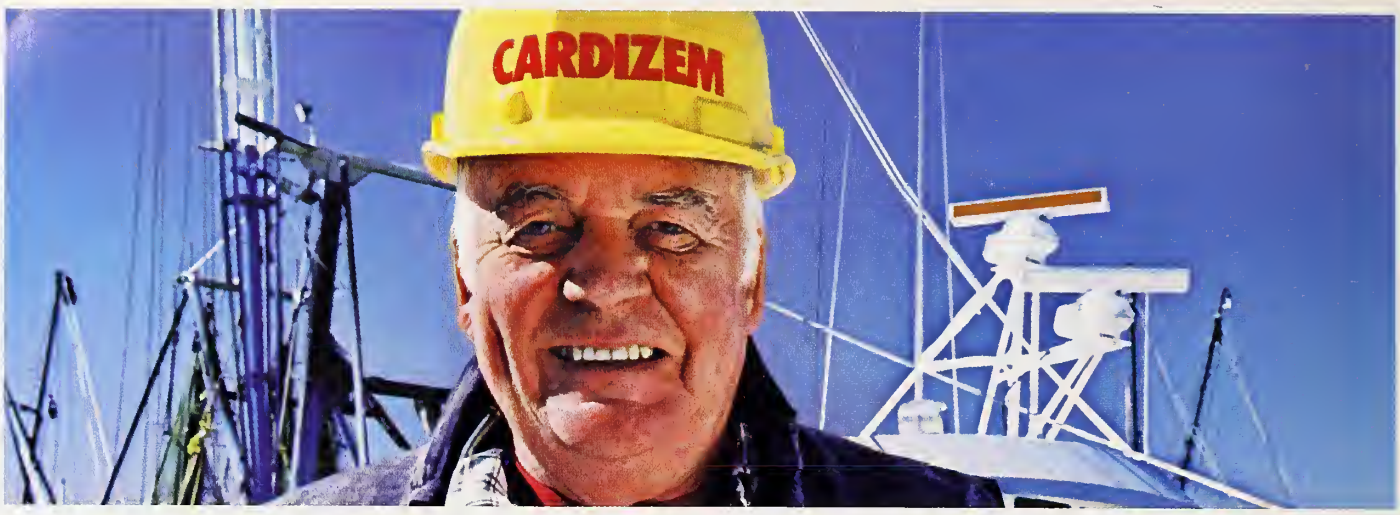


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**WARNINGS**

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

**PRECAUTIONS**

**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

**Drug Interaction.** Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

**Pediatric Use.** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS**

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

| | |
|---|---|
| Cardiovascular: | Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope. |
| Nervous System: | Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor. |
| Gastrointestinal: | Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase. |
| Dermatologic: | Petechiae, pruritus, photosensitivity, urticaria. |
| Other: | Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties. |

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

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# Anticipatory Nausea and Vomiting

*Ann T. Foltz, R.N., D.N.S.*

***"This article reviews the mechanisms involved in nausea and vomiting, the variables identified as possible precursors of anticipatory nausea and vomiting, and selected investigations in the management of this phenomenon."***

NAUSEA AND VOMITING are frequently identified side effects of chemotherapy. Perhaps more importantly, patients perceive vomiting and nausea as the two most severe side effects of drug therapy.[1] In addition, from 10 to 44% of patients receiving chemotherapy experience nausea and/or vomiting in *anticipation* of treatment.[2-4] There has been recent interest in identification of the predisposing factors of anticipatory nausea as well as in measures which prevent or minimize the phenomenon. This article reviews the mechanisms involved in nausea and vomiting, the variables identified as possible precursors of anticipatory nausea and vomiting, and selected investigations in the management of this phenomenon.

Vomiting is controlled by two centers, the chemoreceptor zone (CTZ) and the true vomiting, or emetic, center (TVC). The CTZ reacts to bloodborne agents, while the TVC responds to input from the vestibular structures, peripheral sources, and supramedullary areas. Thus, both centers may be activated by chemotherapy. Moreover, the possibilities of interconnections between the CTZ and TVC and the existence of additional pathways of emetic stimulation exist, although they are not well documented.[5] Anticipatory nausea is usually described as an example of classical conditioning[2] or the pairing of the sensation of chemotherapy-induced nausea/vomiting with unrelated stimuli. Common stimuli include the odor of alcohol wipes used in skin preparation, taste sensations related to circulating chemotherapy, or even the physical appearance of the outpatient area. Cella and others[6] note that olfactory cues are more commonly associated with anticipatory nausea than sight-related stimuli. Other researchers suggest that stimuli associated with anticipatory nausea include those presented apart from the immediate administration period. Bernstein et al,[7] for example, induced taste aversion to a novel flavor of ice cream in children who ingested the ice cream prior to receiving chemotherapy. Whether such aversion occurs in more natural settings, i.e., in a time period and setting more consistent with usual administration practices, where food ingestion does not take place in the same facility and immediate time frame as chemotherapy administration, is less clearly shown

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This paper was sponsored by the Georgia Division of the American Cancer Society. Those wishing to contribute papers to this Section should send them to Thomas W. Phillips, M.D., CANCER Section Editor, 25 Prescott St., Atlanta, GA 30365.

It has been suggested that etreatment anxiety may trigger the isodes of anticipatory nausea which ecede scheduled chemotherapy by nutes or hours. Both state- and it-anxiety levels have been gnificantly higher in patients with ticipatory nausea than the levels easured in patients who did not ve anticipatory nausea.[8-10] Other ychologic states which have been sociated with anticipatory nausea clude increased hostility and pression.[10] The investigation ggesting the importance of these ter factors was retrospective, wever, and it is difficult to termine whether the depression and stility existed before the velopment of the anticipatory usea.

***"Continued research individual and eatment-related factors needed in order to entify susceptible tients in need of eatment."***

Variables other than mood states which have correlated with the development of anticipatory nausea and vomiting include age, emetigenicity of the drugs prescribed, history of postchemotherapy nausea and vomiting, gender, stress, and pre-treatment hours of sleep. Several investigators have suggested that younger adults are more susceptible to anticipatory nausea,[4, 10] but it is unclear whether drug emetigenicity and treatment doses were of equal degree between age groups. Moreover, studies of anticipatory nausea in pediatric patients report that older children were more apt to develop anticipatory nausea.[11] In that study, the investigators specifically noted that the older patients received agents with higher emetigenic potential, had been treated for longer periods, and had experienced more post-chemotherapy nausea before the onset of anticipatory nausea. The impact of age on development of anticipatory nausea, therefore, has not been clearly demonstrated. The relationship between anticipatory nausea development and the number of courses of therapy and problems of earlier post-chemotherapy nausea/vomiting, however, have been noted by several investigators.[4, 12, 13]

Several researchers of adult cancer patients have indicated that women were more at risk to develop anticipatory nausea than men. However, like the older pediatric patients, the women under study commonly received two highly emetogenic drugs in comparison to the men, who were receiving only one such drug.[14] Reduced sleep in the 24 hours preceding chemotherapy has been related to increased nausea and vomiting with cis-platinum therapy.[15, 16] Still other investigators have found that stress within the family may produce greater gastrointestinal symptomatology.[17] It

***"Anxiety, history of prior chemotherapy-induced nausea, and length of treatment course do appear to be the most consistent predictive variables identified."***

is, therefore, not clear which variables are most predictive of the development of anticipatory nausea and vomiting. Anxiety, history of prior chemotherapy-induced nausea, and length of treatment course do appear to be the most consistent predictive variables identified. Further study in this area is needed

before susceptible patients can be identified reliably.

Treatment of chemotherapy-induced nausea has relied primarily on pharmacologic approaches. Since the 1970s, nonpharmacologic methods have also been employed. Interestingly, the nonpharmacologic approaches have been used more consistently in the treatment of anticipatory nausea, although there have been some recent attempts to employ anxiolytics in treatment. A recent trial of clonidine revealed a significant reduction in the duration, but not number, of episodes of anticipatory nausea and vomiting.[18] This area of treatment should be expanded to include those agents already known for their effectiveness in the cancer population.

The nonpharmacologic techniques of distraction and/or counterconditioning have been the principle treatments for anticipatory nausea. Distraction consists of the use of a behavior, like guided imagery or relaxation, which is to be employed during the period of susceptibility. This behavior then provides competing stimuli to the TVC and blocks the reception of nausea/vomiting inducing stimuli. In counterconditioning, the patient is first taught to identify existing stimulus pairs and then to purposely alter either the stimulus or the response to the stimulus with a new behavior. That new behavior may also act as a distraction. The counter-conditioning techniques which have been studied include hypnosis, relaxation, imagery, and systematic desensitization.

LaBaw first used self-hypnosis in a group of 27 children and reported diminished anticipatory nausea and vomiting.[19] Barr and colleagues noted that hypnosis provided antiemetic activity which may have augmented the response to antiemetic drug therapy.[20]

Several investigators have combined aspects of hypnosis with relaxation. Redd et al. noted that deep muscle relaxation reversed anticipatory nausea effectively.[21] Relaxation and guided imagery have been used together in both pediatric and adult population for the control of nausea and vomiting.[22-24] Work with adult patients indicates that relaxation reduces anticipatory nausea and vomiting as well.[24] Carey and others performed a prospective randomized trial in which patients were assigned to receive antiemetics with or without relaxation and guided imagery. Those receiving relaxation developed significantly less anticipatory nausea and vomiting than controls. Morrow and Marrell combined systematic desensitization to the environment and relaxation training and compared that therapy to supportive counseling and control groups. Standard antiemetic therapy was used equally by all groups. Anticipatory nausea and, to a lesser extent, vomiting, were reduced in the desensitized group.

## Summary

Anticipatory nausea and vomiting are significant side effects of chemotherapy. Continued research of individual and treatment-related factors is needed in order to identify susceptible patients in need of treatment. The intervention trials performed indicate that nonpharmacologic techniques can minimize or reverse anticipatory nausea and vomiting and should be instituted early. However, the populations tested have been small, and investigation of more cost-effective and time-efficient methods should be explored. Because of the labor-intensive nature of the nonpharmacologic techniques, more attention to pharmacologic interventions might be helpful. Research into these areas will improve the control of this physically and psychologically debilitating side effect of chemotherapy.

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## PERSONALS

*First District*

**Wesley J. Ball, M.D.,** of Savannah, was installed as chief of staff of Candler General Hospital at their annual meeting in January.

**Paul A. Whitlock, M.D.,** of Statesboro, a member of the Bulloch Memorial Hospital medical staff, was recently selected as a member of the Society of American Gastrointestinal Endoscopic Surgeons (SAGES).

*Second District*

**David A. Cullison, M.D.,** a dermatologist, joined the Archbold-Brooks Specialty Clinic in Quitman.

*Fifth District*

**Walter F. Anderson, M.D.,** was recently named medical director of CPC Parkwood Hospital. Dr. Anderson was formerly Program Director of Adult Psychiatric Services at CPC Parkwood Hospital.

**Brit B. Gay, Jr., M.D.,** of Atlanta, was honored at the February meeting of the Greater Atlanta Pediatric Society with a This-Is-Your-Life program for his 23 years as head of the Pediatric Radiology Department at the Henrietta Egleston Hospital for Children. He was presented with the Katherine Dodd Award for his work in pediatrics.

*Sixth District*

**James D. Thacker, Jr., M.D.,** has opened an anesthesiology practice at AMI Griffin-Spalding Hospital. He is a Medical College of Georgia graduate and did post-doctoral training at Lloyd Noland Hospital in Fairfield, AL.

*Seventh District*

**Marvin Mills, M.D.,** a cardiologist, has been elected chief of staff of Hutcheson Medical Center in Fort Oglethorpe.

*Eighth District*

**David Retterbush, M.D.,** of Valdosta, recently was awarded diplomate status by the American Board of Surgery. Dr. Retterbush is on staff at South Georgia Medical Center where he is currently secretary of the Medical Staff and a member of the Executive Committee.

*Tenth District*

**Paul McDonough, M.D.,** a professor of obstetrics and gynecology at the Medical College of Georgia and Director of the University's Section of Reproductive Endocrinology, Fertility and Genetics, recently was installed as President of the South-Atlantic Association of Obstetricians and Gynecologists.

**Lawrence Devoe, M.D.,** chief of Maternal-Fetal Medicine in MCG's Department of Obstetrics and Gynecology, recently received the Foundation Award of the South Atlantic Association of Obstetricians and Gynecologists.

## DEATHS

*Thomas J. Busey, Sr., M.D.*

Thomas J. Busey Sr., M.D., died of natural causes at his home in Fayetteville on January 27, 1987.

Dr. Busey was born in Monroeville, AL, on June 26, 1894. He attended Auburn University, then earned his medical degree from Emory University School of Medicine in 1916. Dr. Busey served as a medical officer in World War I where he met and later married an Army nurse who remained his co-worker until her death. During World War II, they operated a small maternity hospital behind his office in Fayetteville.

While in practice for more than 50 years, he was president of the Fayette-Clayton Medical Society for several terms, director of the American Academy of General Practice, president of the Fourth (now Sixth) District Medical Society, a 50-year member of both the American Med Association of Georgia, and examin physician for the Veterans Administration as well as the Selec Service from its inception in 1940. was company surgeon for the Centr Georgia Railroad for more than 30 years.

Dr. Busey is survived by three daughters, one son, nine grandchildren, and six great-grandchildren.

*John Bush, M.D.*

John Bush, M.D., of Columbus died recently at the age of 91.

Dr. Bush was well known for building and operating the three-sto Bush Hospital in Columbus. He liv in Columbus most of his life and sp the past 10 years in Russell County He was a U.S. Army veteran of W War I.

Dr. Bush is survived by his wife one son, one daughter, nine grandchildren and six great-grandchildren.

*Nelson O. Tyrone, Jr., M.D.*

Nelson O. Tyrone, Jr., M.D., a urologist, died suddenly at the age 47 while playing tennis. He had be living in Columbus since 1971.

Dr. Tyrone attended Vanderbilt University and graduated from Tula Medical School. He received his specialty training at the University Virginia. Dr. Tyrone served on the executive committee at St. Francis Hospital, where he was also chairm of the Department of Urology. He also on the medical staffs of The Medical Center, Doctors Hospital, Hughston Sports Medicine Hospital

Dr. Tyrone is survived by his wi one son, one daughter, his mother, and a brother.

# ZOVIRAX® (acyclovir) CAPSULES

## Help free your patients from recurrences.

## Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks —month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

## Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

## Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

*Please see brief summary of prescribing information on next page.*

"Living in the city
is lonely enough...
with herpes it's like
solitary confinement."
ZOVIRAX®
(acyclovir)
CAPSULES
Prevent genital herpes
recurrences
month after month with
daily therapy.
(In controlled studies, recurrences were
totally prevented for 4 to 6 months in up to
75% of patients.)
Please see last page of this advertisement for
brief summary of prescribing information.

# Prevent recurrences month after month*

# ZOVIRAX® (acyclovir) CAPSULES

Brief Summary

**INDICATIONS AND USAGE:** Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psychosocial difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

**First Episodes** (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

**Recurrent Episodes:**

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

**CONTRAINDICATIONS:** Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

**WARNINGS:** Zovirax Capsules are intended for oral ingestion only.

**PRECAUTIONS: General:** Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

**Drug Interactions:** Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the $F_1$ generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

**Pregnancy:** ***Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS — Short-Term Administration:** The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

**Long-Term Administration:** The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

**DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes:** One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

**Chronic suppressive therapy for recurrent disease:** One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

**Intermittent Therapy:** One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

**Patients With Acute or Chronic Renal Impairment:** One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance $\leq 10$ ml/min/1.73/m$^2$.

**HOW SUPPLIED:** Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200"- Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

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*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

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# ADVERTISING INDEX


Air Force Reserve ..... 278

Allscrips ..... 226

AMA Hospital Medical Staff ..... 274

AMA Speakers Training/Health Reporting Conference . 276

Arthritis Foundation ..... 282

Atlanta Magnetic Imaging ..... 275

Ayerst Laboratories ..... 234A-D, 266B-D

Blue Cross/Blue Shield ..... 265

Burroughs Wellcome ..... 291

Classifieds ..... 283

CNA Insurance Company ..... 240

CPC Parkwood Hospital ..... 273

Hangar One ..... 225

Health Quip, Inc. ..... 248

Kings Bridge ..... 266

Knoll Pharmaceutical ..... 226A-B

Lilly, Eli & Company ..... 228

MAG Mutual Insurance Company ..... 224

Marion Laboratories, Inc. ..... 282A-B

Medic Computer Systems ..... 267

Medical Expo ..... 250

MONY Credit Corp. ..... 259

Pfizer ..... 250B-D

President's Committee on Employment of the Handicapped ..... 254

Ridgeview Adolescent Program ..... 273, 275, 277

Roche Laboratories ..... 248, 249, 293, 294

Smith Kline and French Labs ..... 250A

Upjohn Company ..... 266A

U.S. Air Force ..... 266

Weight Watchers of Greater Atlanta ..... 248

Woodridge Hospital ..... 259


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**STYLE** — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

**NEWS NOTES** — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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MAY 1987

# JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

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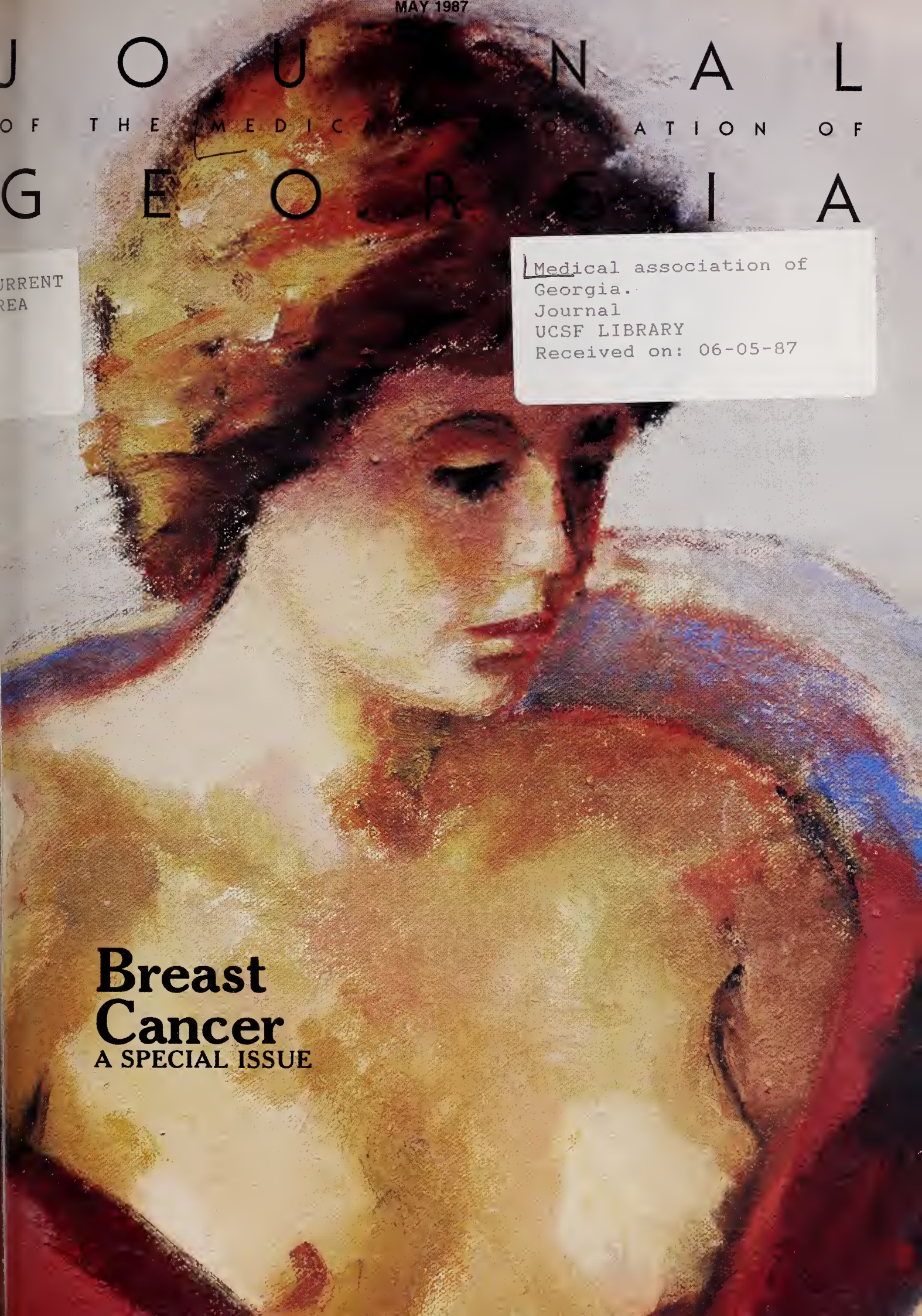
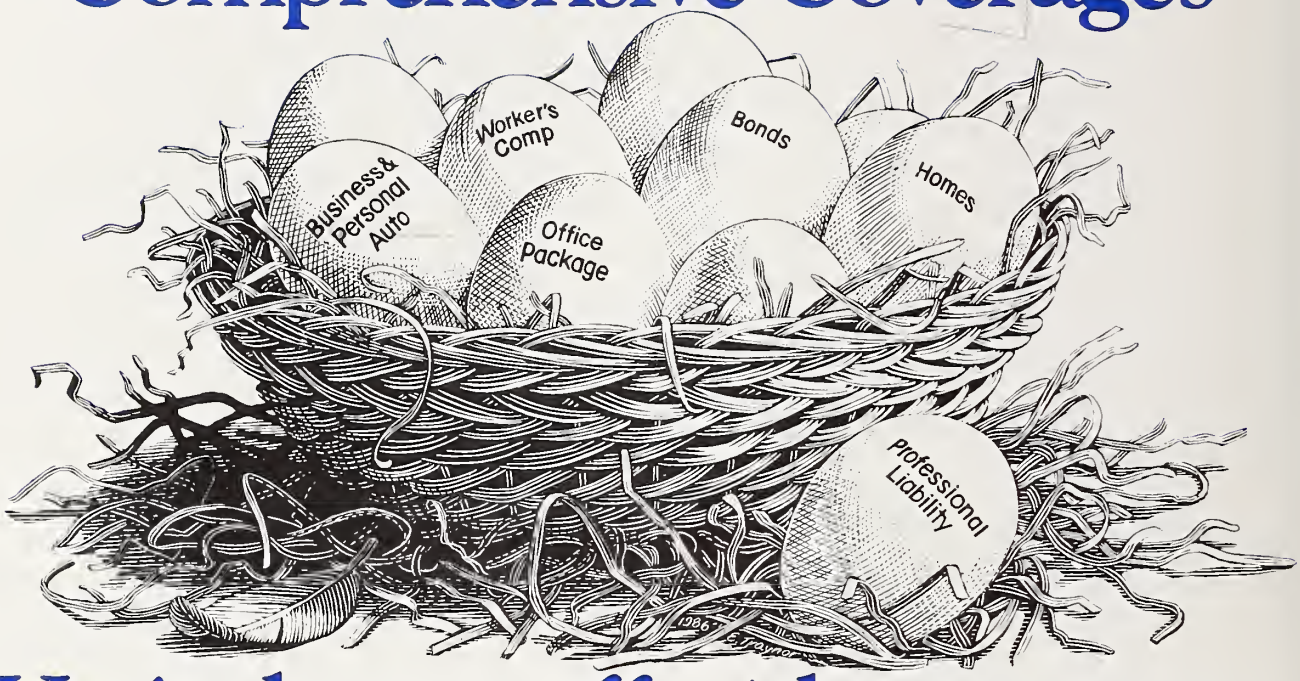


## Breast Cancer
A SPECIAL ISSUE

# With MAG Mutual Agency's Comprehensive Coverages

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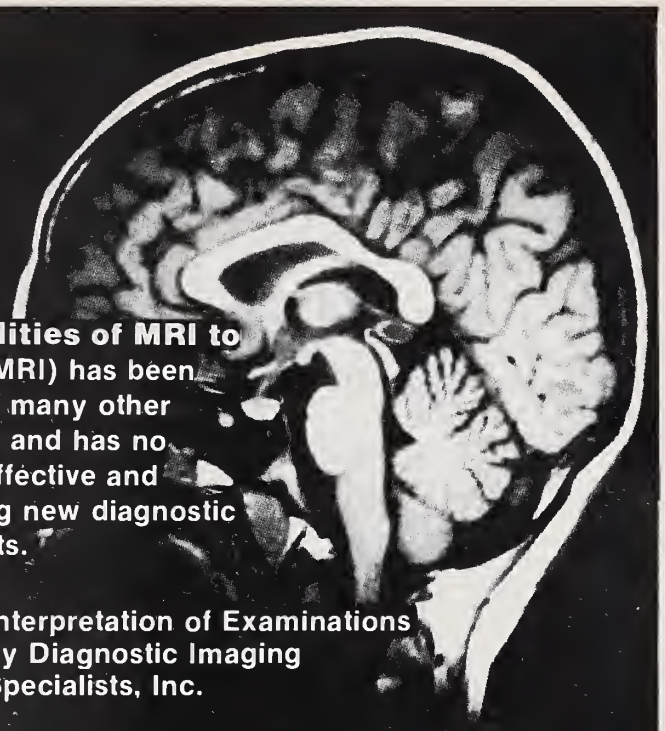

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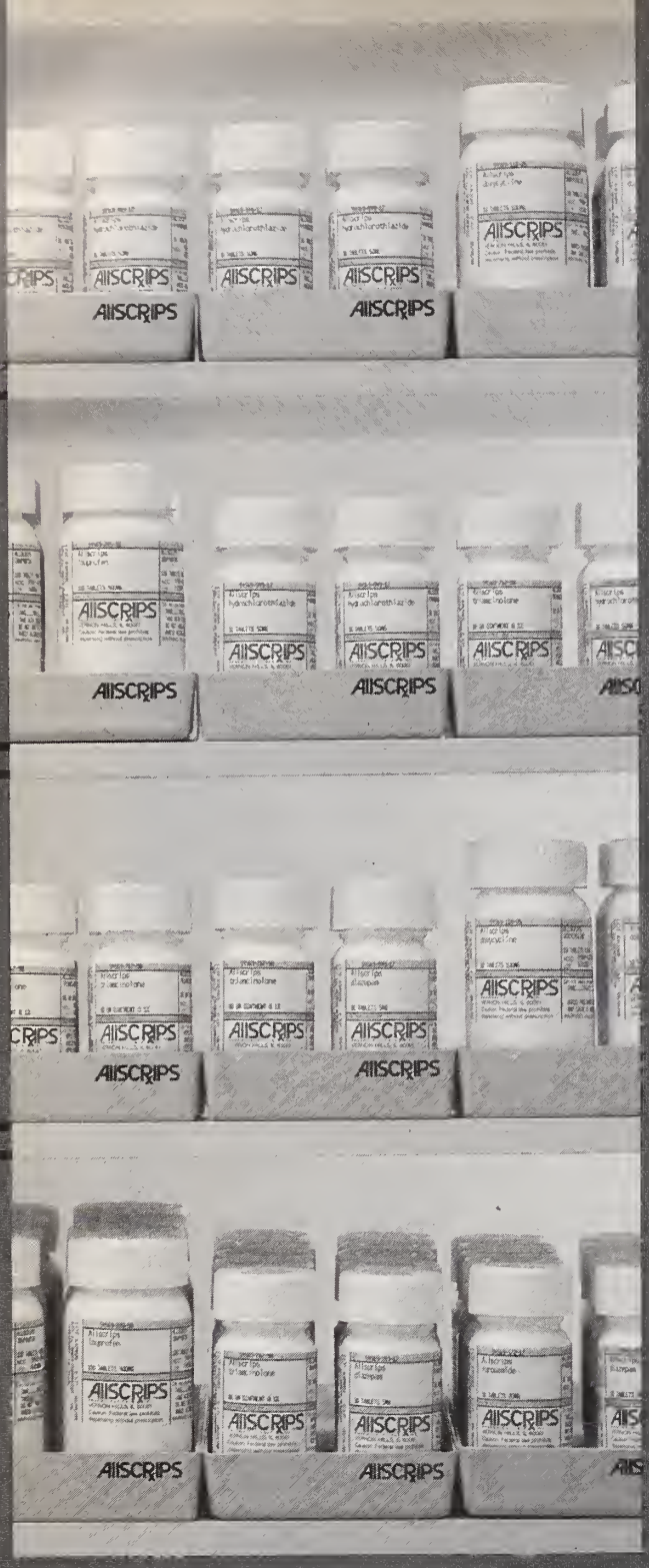


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- ***Antianginal action includes dilatation of coronary arteries, a decrease in vascular resistance/afterload, and a reduction in heart rate***
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- ***Compatible with other antianginals***[2,3*]
- ***A safe choice for angina patients with coexisting hypertension, asthma, COPD, or PVD***[4,5]

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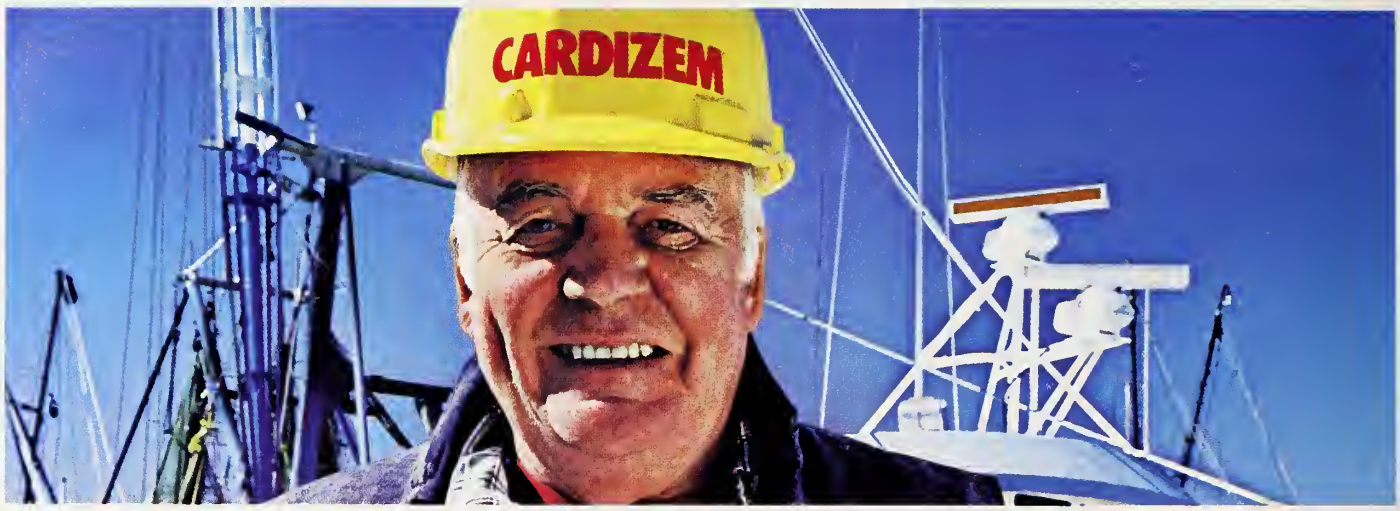
***See Warnings and Precautions.**

*Please see brief summary of prescribing information on the next page.*




# CARDIZEM® FEW SIDE EFFECTS IN ANTIANGINAL THERAPY

diltiazem HCl/Marion

60 mg tid or qid

**Brief Summary**
Professional Use Information

**CARDIZEM®**
(diltiazem HCl) 30 mg and 60 mg Tablets

**CONTRAINDICATIONS**

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

**WARNINGS**

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

**PRECAUTIONS**

**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

**Drug Interaction.** Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

**Pediatric Use.** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS**

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

| | |
|---|---|
| Cardiovascular: | Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope. |
| Nervous System: | Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor. |
| Gastrointestinal: | Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase. |
| Dermatologic: | Petechiae, pruritus, photosensitivity, urticaria. |
| Other: | Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties. |

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 7/86

See complete Professional Use Information before prescribing.

**References: 1.** Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983; 106(6):1341-1347. **2.** Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984;24(Dec):150-159. **3.** Johnston DL, Lesoway R, Human DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687. **4.** Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. **5.** Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.

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# CONTENTS

VOLUME 76, NUMBER 5

## FEATURES

SCREENING FOR BREAST CANCER 310
By Charles M. Huguley, Jr., M.D.

THE SURGICAL MANAGEMENT OF BREAST CANCER 315
By Ralph W. Powell, M.D.

BREAST RECONSTRUCTION FOLLOWING MASTECTOMY 328
By Carl R. Hartrampf, Jr., M.D., Paul W. Black, M.D., Philip H. Beegle, Jr., M.D.

REHABILITATION AFTER MASTECTOMY 336
By John Bostwick, M.D.

PSYCHOSOCIAL ASPECTS OF BREAST CANCER 346
By Rose F. McGee, Ph.D., Jane C. Clark, M.N., Ann T. Foltz, D.N.S.

THE ROLE OF RADIATION THERAPY IN THE TREATMENT OF BREAST CANCER 349
By John Duttenhaver, M.D.

## EDITORIAL

BREAST CANCER TREATMENT — NOT AS SIMPLE NOW 307
By Thomas W. Phillips, M.D.

## DEPARTMENTS

ABOUT THE ARTIST, CONSTANTIN CHATOV 300
CALENDAR 301
PRESIDENT'S PAGE 302
ASSOCIATION NEWS 303
EDITOR'S CORNER 308
INDEX TO ADVERTISING/ MANUSCRIPT INFORMATION 356

## COVER

The cover of this month's special issue devoted to breast cancer, sponsored by the Georgia Division of the American Cancer Society, features a painting by noted Atlanta portrait artist, Constantin Chatov. See page 300 for more information about this gifted man.
The pensive solemnity of the woman on the cover reminds us to consider the whole woman when treating the malignancy within her breast(s).
Cover photograph by Chuck Rogers, Atlanta.

# ABOUT THE COVER ARTIST

## Constantin Chatov

OUR COVER ARTIST this month is Constantin Chatov, an artist well known throughout the Southeast. Since his residence is in Atlanta, he has contributed immeasurably to the artistic and cultural growth of the city. He was selected by the Georgia Arts Alliance to receive one of the 1983 Governor's Awards in the Arts. In 1986, Mr. Chatov exhibited his work at the State Capitol, along with works by his brother and nephew, and was subsequently given an award by Gov. Joe Frank Harris "In Appreciation for Participation In The Governor's Georgia Artist Of Excellence Program." He is well known in Atlanta for his portrait work and his figure studies in particular.

Mr. Chatov studied at the New York Art Students League with Harry Sternberg, Robert Brackman, George Grotstz, and Will Barnet. He was a classical pianist up to 192 Later, his interest turned to painting.

Mr. Chatov's paintings have been exhibite in two-man shows at the High Museum of A and Museums of Columbus, Albany, Dalton, Gainesville, Macon, Montgomery, Mobile, ar many galleries. He has exhibited in many juried shows including the High Museum Southeastern Annual, Hunter Museum Annu Callaway Gardens Annual, and Savannah Museum Annual. He once judged the Annua Alabama State Art Show in Montgomery.

He has painted portraits of many promine Atlantans and others throughout the United States. Among them are: I. M. Sheffield, Jr., Hal Davison, Mrs. Ray Moore, Dorothy Alexander, many members of the Nunnally families, members of the family of Mrs. Irlar of Birmingham, President of Emory Universi Dr. Laney, Henry Bowden, William Bowdoin the conductor of the Metropolitan Opera Fausto Cleva, Metropolitan star Nell Rankin, pianist Leonard Pennario and Veronica Lake in London the family of Harry Wingate. He was commissioned by Metro Goldwyn Meyer to paint a portrait of Margaret Mitchell.

We are indebted to Mr. Chatov for his generosity in allowing us to photograph one his paintings to introduce this special issue devoted to the detection and management c breast cancer. The pensive solemnity of the woman on the cover reminds us to conside the whole woman when treating the malignancy within her breast(s).

Cover photo by Chuck Rogers of Atlanta.

## MAY

29 — *Atlanta:* **Advances in the thophysiology, Diagnosis, and atment of Cardiovascular Dis-ses.** Category 1 credit. Contact ot. of CME, Emory Univ. Sch. of d., 1440 Clifton Rd., Atlanta 30322. :404/727-5695.

29 — *Callaway Gardens:* **15th nual Perinatal Medicine Confer-e.** Category 1 credit. Contact Div. Perinatology, The Medical Ctr., ). Box 951, Columbus 31994. 404/571-1000.

## JUNE

1 — *Sea Island:* **Twelfth Annual nposium on Lung Disease.** Cat-ry 1 credit. Contact American g Association of Georgia, 2452 ng Rd., Smyrna 30080. PH:404/ -5864.

0 — *McCormick, SC:* **Seizure orders in Children.** AMA Cate-1 and AAFP prescribed credit. tact Div. of Cont. Ed., MCG, Au-a 30912. PH:404/828-3967.

4 — *Kiawah Island, SC:* **Update ynecology.** Category 1 credit. tact Div. of Cont. Ed., MCG, Au-a 30912. PH:404/828-3967.

8 — *Kiawah Island, SC:* **18th ual Internal Medicine Sympos-**. Category 1 credit. Contact Div. ont. Ed., MCG, Augusta 30912. 04/828-3967.

1 — *Sea Island:* **Georgia Chap-of the American Academy of atrics Spring Meeting.** Cate-1 credit. Contact William C. kin, Exec. Secy., Ga. Chapter, , 4059 Land O'Lakes Drive, At-30342. PH:404/237-3922.

7 — *Hilton Head Island, SC:* **y Anesthetic Challenges —** . AMA Category 1 and AAFP cribed credit. Contact Div. of . Ed., MCG, Augusta 30912. 04/828-3967.

29-July 2 — *Kiawah Island, SC:* **Hematology-Oncology Symposium.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

## JULY

7-10 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

9-11 — *Kiawah Island, SC:* **7th Annual Clinical Obstetrics.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

10-11 — *Savannah:* **SMA's Clinical Postgraduate Conference.** Category 1 credit. Contact Jeanette Stone, SMA, P.O. Box 190088, Birmingham, AL 35219-0088. PH:205/945-1840.

13-16 — *Kiawah Island, SC:* **Clinical Cardiology.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

21-25 — *Kiawah Island, SC:* **10th Annual Critical Care Medicine.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

27-29 — *Kiawah Island, SC:* **10th Annual Pediatric Update 1987.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

27-29 — *Atlanta:* **American Hospital Association.** Contact AHA Office, 36 S. State St., Salt Lake City, UT 84111.

27-30 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/727-5695.

## AUGUST

2-5 — *Atlanta:* **International Society for STD Research.** Category 1 credit. Contact: Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/727-5695.

3-8 — *Hilton Head Island, SC:* **12th Annual Your Practice, Your Money, Your Family.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

10-14 — *Atlanta:* **Summer Imaging and Interventional Techniques V. Category 1 credit.** Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

13-16 — *Hilton Head Island, SC:* **Ga. Psychiatric Association's Summer Meeting.** Category 1 credit. Contact James Moffett, Dir. of Specialty Society Relations, MAG, 938 Peachtree St., Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

17-21 — *Atlanta:* **A Comprehensive Board Review in Internal Medicine.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

20-23 — *Kiawah Island, SC:* **Pulmonary Disease Review.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

24-28 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch.of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

29-30 —*Callaway Gardens:* **Joint Meeting of the Ga. Society of Anesthesiologists and the Alabama Society of Anesthesiologists.** Category 1 credit. Contact William D. Hammonds, M.D., Secy-Treas., GSA, Dept. of Anesth., Emory Univ. Hosp., 1465 Clifton Rd., Atlanta 30322. PH:404/321-0111 ext. 3900.

# *It's Your Organization*

*Jack F. Menendez, M.D.*

In this, my first, President's Page, I would like to give an overview of how the Medical Association of Georgia (MAG) functions as well as describe its goals and organizational structure.

MAG is first and foremost a democratic organization; the dues-paying members elect Delegates and Alternate Delegates (one each per 25 dues-paying members). Delegates are also elected by the Resident Section, the Medical Student Section, and the Hospital Medical Staff Section. These Delegates meet in April each year to transact the business of the Association. In addition to the House of Delegates, the members also elect Directors who meet quarterly to keep the business of the Association on track; the Board of Directors also organizes the Executive Committee, comprised of the officers of the House of Delegates and the Board of Directors. The Executive Committee meets monthly to implement the directives of the House.

So there is a "chain of command," the House of Delegates meeting annually to set the course of action for the year; the Board of Directors meeting quarterly to carry out the mandates and policies of the House of Delegates; the Executive Committee meeting monthly to carry out the day-to-day functions of the Association. The Association requires membership involvement to serve as committee members, delegates, directors, and officers. Only members can serve in these posts.

In addition to membership involvement, MAG has a fulltime professional staff of 28 people. Our staff, headed by Mike Fowler, works for the membership. They are accessible to our members and stan ready to assist any member with questions concerning MAG activiti or policies.

MAG is involved in ongoing activities in many areas, including Publishing, Education, Medical Practice, Legislation, Insurance, Pe Review and Public Relations, eithe by MAG itself or its affiliated organizations. These organizations include MAG Mutual, GaMPAC, t Georgia Medical Care Foundation, and the Georgia Health Network.

Recently, MAG has initiated several public relation campaigns i order to lessen the medical consequences of such problems as child abuse, health care for the unemployed, and teenage pregnanc In the area of Alternate Health Car MAG has formed its own IPA-HM in order to provide a physician-run system. MAG is also involved in legislative activities. We have a skilled lobbying team that participates in the shaping of healt care-related legislation. MAG form an insurance company, MAG Mutual, in 1982 to provide the physicians of Georgia security in t area of Professional Liability Insurance.

In these and many other activitie the common denominator is patient advocacy. We do not undergo any activity for self-interest. By being our patient's advocate, we retain o credibility with government, the insurance industry, but most importantly of all, with our fellow physicians.

Jack F. Menendez

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**Brief Summary. Consult the package literature for prescribing information**

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Otitis media due to *S pneumoniae, Haemophilus influenzae*, staphylococci, streptococci, and *Neisseria catarrhalis*

Skin and skin-structure infections caused by staphylococci and/or streptococci

Bone infections caused by staphylococci and/or *Proteus mirabilis*

Genitourinary tract infections, including acute prostatitis, caused by *Escherichia coli, P mirabilis*, and *Klebsiella* sp.

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**Contraindication:** Keflet is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflet.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile*. Other causes of colitis should be ruled out.

*Usage in Pregnancy*—Safety of this product for use during pregnancy has not been established.

**Precautions:** *General*—Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflet may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Keflet should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflet, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

*Usage in Pregnancy—Pregnancy Category B*—The daily oral administration of cephalexin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalexin during pregnancy in humans has not been established.

Cephalexin showed no enhanced toxicity in weanling and newborn rats as compared with adult animals. Nevertheless, because the studies in humans cannot rule out the possibility of harm, Keflet should be used during pregnancy only if clearly needed.

*Nursing Mothers*—The excretion of cephalexin in the milk increased up to 4 hours after a 500-mg dose; the drug reached a maximum level of 4 μg/ml, then decreased gradually, and had disappeared 8 hours after administration. Caution should be exercised when Keflet is administered to a nursing woman.

**Adverse Reactions:** *Gastrointestinal*—Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

*Hypersensitivity*—Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported.

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## PERSONALS

*First District*

**Carter L. Meadows, M.D.,** a surgeon from Swainsboro, has been appointed chief of staff at Emanuel County Hospital and Nursing Home.

*Third District*

**Stephen R. Cherry, M.D.,** a cardiologist who recently opened an office in Columbus, has been inducted as a fellow of the American Academy of Cardiology. He was an instructor of cardiology and assistant professor of internal medicine at St. Louis University.

*Fourth District*

**Robert Fine, M.D.,** of Decatur, was recently appointed Clinical Associate Professor of Pathology at Emory University School of Medicine. He currently holds an appointment as Clinical Professor in Dermatology.

**Richard Stappenbeck, M.D.,** has opened an office for the practice of neurology at the Clayton Professional Building. Dr. Stappenbeck has practiced in the Clayton area for 8 years and is on the medical staff of Clayton General Hospital, where he is Chief of Staff-Elect.

**Elliott C. Moon, M.D.,** has been elected chief of medical staff at DeKalb General Hospital. Dr. Moon has served as OB/GYN section chief and secretary of medical staff at DeKalb General and is a clinical associate at Emory University School of Medicine.

*Fifth District*

**Nanette K. Wenger, M.D.,** was elected as Secretary of the American College of Cardiology at the 36th Annual Scientific Sessions held in March.

**Charles Hugueley, M.D.,** Professor of Medical Oncology at Emory University School of Medicine, has been named President-Elect of the Georgia Division of the American Cancer Society.

*Seventh District*

**Richard Cohen, M.D.,** will head the new Georgia Joint Replacement Service office in Cobb County.

**Earl T. McGhee, M.D.,** of Dalton, announced his retirement after 35 years.

*Ninth District*

**Arthur E. Carpenter, M.D.,** the medical director of the chemical dependency unit at Northeast Georgia Medical Center, has recently become certified in addictionology by the American Medical Society on Alcoholism and Other Drug Dependencies. Prior to coming to the Medical Center, Dr. Carpenter worked for six years at Ridgeview Hospital in Smyrna.

## QUOTES

*The most I can do for my friend is simply to be his friend.*
HENRY DAVID THOREAU

*If you wish success in your life, make perseverance your bosom friend, experience your wise counsellor, caution your elder brother, and hope your guardian genius.*
JOSEPH ADDISION

*We are always in the forge, or on the anvil; by trials God is shaping us for higher things.*
HENRY WARD BEECHER

*It is difficult to get a man to understand something when his salary depends upon his not understanding it.*
UPTON SINCLAIR

*To suppose, as we all suppose, that we could be rich and not behave as the rich behave, is like supposing that we could drink all day and stay sober.*
LOGAN PEARSALL SMITH

*There is nothing more irrational than a man who is rationally irrational.*
LECOMTE DU NOÜY

*Men who are rich have times when they don't listen. Men who are qui bright have times when they don't listen. Men who are both bright an rich* always *listen. That is how the got the money, and that is how the keep it.*
JOHN D. MACDONALD

*The world gets better every day — then worse again in the evening.*
KIN HUBBARD

*Life, not death, is the great adventure.*
SHERWOOD ANDERSON

*Make few resolutions. Make specif resolutions. And fulfill them with th help of God.*
JOSEMARIA ESCRIVA

*A man should never be ashamed t own he has been in the wrong, wh is but saying in other words, that h is wiser today than he was yesterd.*
ALEXANDER POPE

*The human condition is such that pain and effort are not just sympto which can be removed without changing life itself; they are rather the modes in which life itself, together with the necessity to whic it is bound, makes itself felt. For mortals, the "easy life of the gods would be a lifeless life.*
HANNAH ARENDT

*Take love away from life and you take away its pleasures.*
MOLIÈRE

*Defeat never comes to a man until admits it.*
JOSEPHUS DANIELS

Source: *Forbes*

# Breast Cancer Treatment — Not As Simple Now

*"The controversies maining will, in time, resolved. The answers ll come from ospective randomized als which are well ntrolled and contain nificant numbers of tients."*

BREAST CANCER is one of the most controversial and complex problems faced by present day physicians. Just 10 to 15 years ago, the treatment of breast cancer was much simpler. A woman found a lump in her breast; she was seen by a surgeon. The surgeon obtained consent to biopsy the lump and perform a radical mastectomy during the same anesthesia. Life was simple, but was this type of treatment appropriate for all patients? The answer seems obvious today. Radical and extended radical mastectomies have been shown to offer no significant survival benefit to the patient over a modified radical mastectomy, but produce significantly higher morbidity.

Since the advent of megavoltage radiation therapy, the radiation oncologists have gotten into the act but can only claim improvement in local control, not survival. But in the 1950s and 1960s in Europe and Canada, several studies suggested that lumpectomy and radiation offered equal survivorship. The main criticism of these studies was the lack of a randomized trial to support the data. Then in the 1970s some large, well controlled, randomized trials were reported which showed that lumpectomy and radiation offered the same cure rate as mastectomy. Even though there have been many subsequent and confirmatory reports, this form of treatment is still viewed with skepticism by many.

Chemotherapy for breast cancer really got started in the late 1960s with the Cooper regimen (CMFVP). But the Milan, Italy, report in 1973 showing 5-year survival in patients with positive axillary nodes to be 64% for those receiving CMF vs. 48% for the controls started the revolution of adjuvant chemotherapy for this disease.

Then came ER and PR receptor assays. Then tumor differentiation, mitotic index, and other variables. So life is definitely not simple today. We must now make decisions based on the parameters found in each patient. We can no longer say all patients should receive this treatment or that treatment. We must individualize.

The controversies remaining will, in time, be resolved. The answers will come from prospective randomized trials which are well controlled and contain significant numbers of patients. Conclusions based on small groups of patients should always be suspect for bias and avoided when making treatment decisions.

The management of the patient with breast cancer requires a coordinated approach involving the surgeon, the radiation oncologist, and the medical oncologist to maximize the curative effort and minimize morbidity.

*Thomas W. Phillips, M.D.*
*Editor,* JMAG *Cancer Section*
*Director, Radiation Therapy Dept.*
*Crawford W. Long Hospital*

# *John Brown Talks of Breast Cancer*

***"A short portion of an essay by John Brown is worth our attention, for in it, he describes, in that beautiful language of the Nineteenth Century, not only the poignancy of the patient afflicted with breast cancer but also helps us understand how far we have come in medicine since the Nineteenth Century."***

YOU WILL find this issue of the *Journal* devoted to that enigmatic of diseases, cancer of the breast. Several authors, themselves organized through the efforts of the Georgia Division of the American Cancer Society, will address the several areas of concern with which one must deal when confronting the patient afflicted with or suspected of breast cancer. The availability of various modalities for early diagnosis and the apparent necessity of such for control of the disease will be given careful attention. And then the ever-changing therapeutic concepts and approaches will be looked at with a critical eye. The impact of the disease and the application of the therapeutic armamentarium upon the psychologic and social milieu of the individual patient will be recognized. We hope it will be a reasonably inclusive survey of the disease of breast cancer.

Although we may tend to think of all this as "modern medicine," it is a centuries-old problem, malignancy of the breast is, where one can find references to the ravages it has produced upon the human race in some of mankind's earliest writings. John Brown (1810-1882) was a Scottish physician and essayist who received his medical education at Edinburgh. He is remembered primarily for his three volumes of *Horae Subsecivae*, a work which includes his two most famous essays, *Marjorie Fleming*, and his memorable dog story, *Rab and his Friends*. It is in the latter essay that John Brown talks of a Nineteenth Century English lady suffering from cancer of the breast. A short portion of that essay is worth our attention, for in it John Brown describes, in that beautiful English of the Nineteenth Century, not only the poignancy of the patient afflicted with breast cancer but also helps us understand how far we have come in medicine since the mid-Nineteenth Century. The main characters are Ailie, the lady suffering from breast cancer; James, her husband; and Rab, the dog so affectionately attached to his mistress. The description is of Ailie, James, and Rab as they encounter the medical staff of what sounds like a "teaching hospital":

*"'As I was sayin', she's got a kind o' trouble in her breast, doctor; wull ye tak' a look at it?' We walked into the consulting room, all four; Rab grin and comic, willing to be happy and confidential if cause could be show willing also to be the reverse, on th same terms. Ailie sat down, undid her open gown and her long handkerchief round her neck, and without a word showed me her righ breast. I looked at and examined it carefully, she and James watching me, and Rab eying all three. What could I say? There it was, that had once been so soft, so shapely, so white, so gracious and bountiful, s "full of all blessed conditions," ha as a stone, a centre of horrid pain, making that pale face, with its gray lucid, reasonable eyes and its swee resolved mouth, express the full measure of suffering overcome. Wh was that gentle, modest, sweet woman, clean and lovable, condemned by God to bear such a burden?*

*" . . . Next day my master, the surgeon, examined Ailie. There wa no doubt it must kill her, and soon It could be removed. It might never return. It would give her speedy relief. She should have it done. She courtesied, looked at James, and said: 'When?' 'To-morrow.' said th kind surgeon, a man of few words. She and James and Rab and I retired. I noticed that he and she spoke little, but seemed to anticipa everything in each other. The following day, at noon, the student came in, hurrying up the great stai At the first landing-place, on a small, well known blackboard, was bit of paper fastened by wafers, an many remains of old wafers beside*

*the paper were the words: 'An ration to-day. J.B. Clerk.'*
*'Up ran the youths, eager to ure good places; in they crowded, of interest and talk. 'What's the e?' 'Which side is it?'*
*'Don't think them heartless; they neither better nor worse than you l; they get over their professional rors, and into their proper work; l in them pity, as an emotion, ling in itself or at best in tears l a long-drawn breath, lessens, ile pity as a motive is quickened, l gains power and purpose. It is l for poor human nature that it is*

*'The operating theatre is wded; much talk and fun, and all cordiality and stir of youth. The geon with his staff of assistants is re. In comes Ailie: one look at her ets and abates the eager students. it beautiful old woman is too ch for them; they sit down, and dumb, and gaze at her. These gh boys feel the power of her sence. She walks in quickly, but hout haste; dressed in her mutch, neckerchief, her white dimity rt-gown, her black bombazine icoat, showing her white worsted kings and her carpet-shoes. ind her was James with Rab. es sat down in the distance, and k that huge and noble head veen his knees. Rab looked plexed and dangerous; forever king his ear and dropping it as .*
*'Ailie stepped up on a seat, and herself on the table, as her nd, the surgeon, told her; nged herself, gave a rapid look at James, shut her eyes, rested herself on me, and took my hand. The operation was at once begun; it was necessarily slow; and chloroform — one of God's best gifts to his suffering children — was then unknown. The surgeon did his work. The pale face showed its pain, but was still and silent. Rab's soul was working within him; he saw that something strange was going on, blood flowing from his mistress, and she suffering; his ragged ear was up and importunate; he growled and gave now and then a sharp, impatient yelp; he would have liked to have done something to that man. But James had him firm, and gave him a glower from time to time, and an intimation of a possible kick; all the better for James, it kept his eye and his mind off Ailie.*

*"It is over: she is dressed, steps gently and decently down from the table, looks for James; then turning to the surgeon and the students, she courtesies, and in a low, clear voice, begs their pardon if she has behaved ill."*

**"'Rab's soul was working within him; he saw that something strange was going on, blood flowing from his mistress, and she was suffering; his ragged ear was up and importunate; he growled and gave now and then a sharp, impatient yelp. . . .'"**

We have, of course, come a long way since those days. No more open amphitheaters, no more chloroform, no more dogs in the operating theater. And yet, on the other hand, we have not come so far. The symbolic Ailie is still around in the form of a long-suffering patient whom fear has kept all too long away from our diagnostic and therapeutic maneuvers. The symbolic James is still with us in the form of the husband and family intimately impacted by all that goes on under our direction in caring for the breast cancer patient. Unfortunately, the surgeon, "a man of few words," is still around in the form of those of us too hurried, too preoccupied, too insensitive, or perhaps on occasion, too unknowledgeable to guide the patient and her famiy through the morass of decisions which need to be made when confronting each patient so afflicted. The student and the house officer, the maturing physician and surgeon, are here, "Don't think them heartless . . . in them pity, as an emotion, ending in itself or at best in tears and a long-drawn breath, lessens, while pity as a motive is quickened, and gains power and purpose."

*Charles R. Underwood, M.D.*
*Editor*

# Screening for Breast Cancer

*Charles M. Huguley, Jr., M.D.*

BREAST CANCER is a major health problem in this country, since more than 40,000 women die of it each year. The death rate has remained steady for 50 years. We have made no improvement in the survival of patients with breast cancer when analyzed within each stage. True, there has been a steady increase in the percentage of women with breast cancer who survive 5 years, but this is attributable to an increase in diagnosis at early stages. Indeed, the major thrust of studies in the last 10 years has been only to show that we can do as well with less therapy, not that we can do better. Until treatment improves substantially, longer survival is going to depend mostly upon earlier diagnosis. Fortunately, we have the means in hand to make a big impact in this direction. Breast cancer can be diagnosed early by mammography, by physician's examination, and by the regular use of breast self-examination (BSE). Of these, by far the most widely practiced is BSE.[1]

*Breast self-examination is not a substitute for annual physical examination and mammography but an effective complement.*

Mammography is the most effective technique for detecting early cancer of the breast, but mammograms cannot be fully interpreted without knowledge of the physical findings. It is occasionally possible to palpate a tumor which is not detected on the mammogram. Our recommendation must be a yearly physical examination and mammogram for all women past 50 and at lesser frequency for those between 35 and 49. We must also recommend that all women past 20 years of age learn to perform breast self-examination and do it once a month.

Between 1973 and 1978, the National Cancer Institute supported Breast Cancer Diagnosis Demonstration Programs (BCDDP) at 29 institutions, including one at Georgia Baptist Hospital and Emory University. The programs enrolled a total of 250,000 women for annual screening for breast cancer by physical examination and mammography and taught them BSE.[2] A total of 4403 cancers of the breast were diagnosed. Of those detected by screening, 32.4% were minimal (non-infiltrating or <1.0 cm). Fewer than 20% had positive lymph nodes. This predominance of early stage cancers predicted a good survival for the group. In women aged 50-59 years, mammography was positive in 91.8% and was the only positive finding in 41.5%. Mammography was negative in only 6.7% of patients identified by physical examination. In women aged 40-49, mammography was positive in 85.4% and the only positive finding in 19.4%. It was negative in 13.1% of those identified by physical examination. Recently, Letton and Mason have reported a follow-up of 8058 women enrolled at the Georgia Baptist Hospital BCDDP.[3] Of the 122 patients discovered to have breast cancer, there has been 100% follow-up for a median of 10.2 years. The survival of the entire group was

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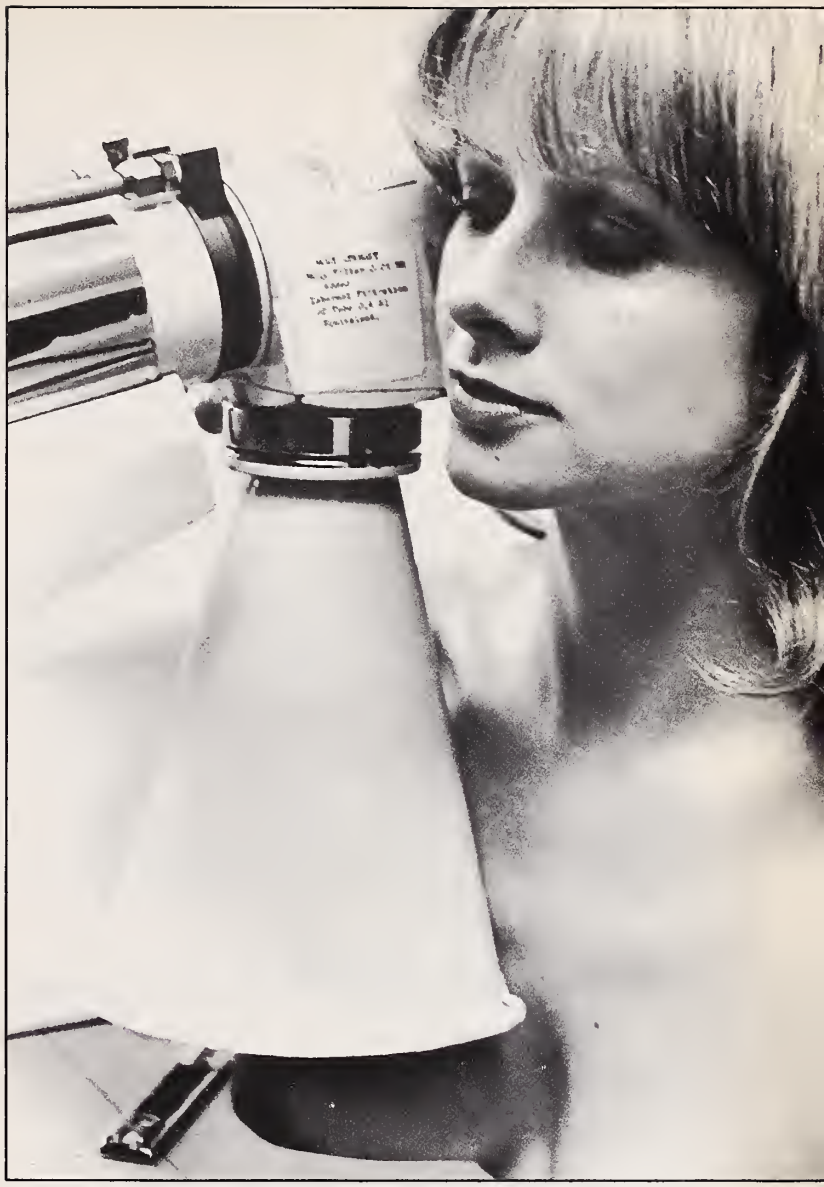
*Mammography is the most effective technique for detecting early cancer of the breast. Since the radiation has been reduced to less than 0.5 rads, there is no longer any reason to fear carcinogenic effects of repeated mammograms.*



90.8%, but the survival of those identified by mammography only was 96.8% (100% of women past 50). These excellent results make it mandatory that we screen all women in the target group regularly and that we direct our efforts especially at the high risk groups. It must be emphasized that the technology of mammography has advanced considerably since the BCDDP, and current effectiveness should exceed that reported.

There has been a fear of the carcinogenic effects of repeated mammograms as was observed in studies 25 years ago. The radiation dose has been reduced from 2 rads per breast to less than 0.5 rads now, and the most recent films are resulting in even less exposure. There is no longer any reason to fear an increased risk of cancer from mammograms.

Despite its usefulness, mammography is not being widely applied, in part because of its expense, but also because of inadequate numbers of modern, dedicated mammography machines and the paucity of well-trained mammographers. Thus, it is not possible to screen all the women in the target group at this time. We do have the capacity to screen many more women than we are screening, and the time is ripe for a concerted drive to educate women to make mammography an annual event and to educate mammographers to reduce the cost. It is quite likely that the increase in usage which would follow a big reduction in charges would reduce the unit cost enough to increase profitability.

*We do have the capacity to screen many more women than we are screening, and the time is ripe for a concerted drive to educate women to make mammography an annual event and to educate mammographers to reduce the cost.*

Much of our information about the usefulness of BSE comes from work done by the ten Breast Cancer Management Network Demonstration Projects funded in 1974-79 by the National Cancer Institute, one of which was the Georgia Breast Cancer Management Network, Inc. This was composed of 14 Georgia centers which operated Cancer Programs approved by the American College of Surgeons: Augusta Radiation Therapy Center, Crawford W. Long Hospital, DeKalb General Hospital, Emory University Hosptial, Enoch Callaway Cancer Clinic, Eugene Talmadge Memorial Hospital, Floyd Hospital, Georgia Baptist Hospital, Grady Memorial Hospital, The Medical Center of Columbus, Medical Center of Central Georgia, Memorial Medical Center of

Savannah, Phoebe Putney Memorial Hospital and St. Joseph's Infirmary. The names of the physicians and nurses involved in our project have been published.[4] Four of these networks, including the Georgia network, have subsequently reported on their experience in relation to BSE.[4-7] In each of the studies which stated the manner of diagnosis, about 80% of the diagnoses were initiated by the finding of an abnormality by the patient herself. In the Georgia experience, 77.9% of the tumors were discovered by the patient, 20.7% by deliberate self-examination. Those women who practiced BSE were more likely to have disease in Stages 0, I, or II (83.5%) than were those women who did not practice BSE (63.5%). The difference was highly significant, $P<0.001$. Women who practiced BSE had smaller tumors on average and were more likely to have tumors smaller than 2.0 cm. and less likely to have tumors larger than 5.0 cm. than were women who did not practice BSE.

*Our survival curves show a gap between breast self-examination practitioners and non-practitioners that continues to widen with the passage of years. This suggests a greater percentage of true cures.*

There are two studies, however, that did not find earlier stages among BSE practitioners.[8, 9] In these studies, patients who practiced BSE less often than three times a year were classed as non-practitioners. We found that 19% of our patients who practiced BSE did so less often than three times a year but at least once a year. The results were as effective as in women who practiced more often. This is not surprising if one reflects on the established effectiveness of mammography and physical examination done once a year. We believe this misclassification may well explain the failure to demonstrate the effectiveness of BSE in the two papers cited.

Our findings suggested that women who practiced BSE would survive longer after the diagnosis of cancer of the breast than women who did not. One of the Breast Cancer Management Networks has published a subsequent study demonstrating that there is indeed a highly significant difference in survival.[10] We are at the moment engaged in analysis of 8-year follow-up data on the women enrolled in the Georgia Breast Cancer Management project. As was expected from the larger number of tumors in early stages among the BSE practitioners, we have found that these women had a considerably greater 5-year survival. The 5-year survival of BSE practitioners was about 75%, as compared to about 60% among non-practitioners. The 80% survival time for the practitioners was approximately 52 months compared to about 26 months for the non-practitioners. We think these differences are greater than can be explained on the basis of earlier stage at diagnosis alone.

There are critics of the findings of the various breast cancer screening programs who believe that breast cancer is never cured and that the longer survival of patients picked up by screening means only that these patients are simply diagnosed earlier and therefore appear to survive longer. These critics believe that the patients die at the same time they would have if diagnosed later but are known to have had the disease for a longer time. This effect is known as "the lead-time bias." We believe that the lengthening of mean survival among BSE practitioners greatly exceeds any reasonable lead time. We know that breast cancer patients may continue to relapse after 15 to 20 years but this happens in only a small percentage. Most 5-year survivors do not relapse. Our survival curves show a gap between BSE practitioners and non-practitioners that continues to widen with the passage of years. This suggests a greater percentage of true cures. We strongly believe that BSE is an effective method of diagnosing breast cancer at an earlier stage, thereby increasing the cures.

*True, there has been a steady increase in the percentage of women with breast cancer who survive 5 years, but this is attributable to an increase in diagnosis at early stages.*

BSE is at its best as an adjuvant technique. It certainly should not be used as a substitute for an annual physical examination or for mammography. On the other hand, it is cost-free and non-toxic and is effective when practiced between annual screening examinations. In the Breast Cancer Detection Demonstration Projects (1973-79), about one-quarter of the incidence cases were discovered in the interval between scheduled annual examinations, many of them by BSE.[2] It would appear foolish to omit BSE from the program. A further advantage is that the practice of BSE involves the patient in responsibility for her own health.

In the real world, we seldom achieve our ideal goals. Women are not taking advantage of the availability and effectiveness of mammography. Yet they have accepted BSE. Current figures on the practice of BSE are not available, but in our 1975-79 study, three-quarters of the patients practiced BSE and, more than a third did so monthly. These figures are very similar to others of about the same time.[1,5] Although the nationwide Breast Cancer Detection Demonstration Projects studying the effectiveness of mammography had been started 2 years before our study with considerable publicity, and although most of our patients lived in the area serviced by one of these projects which made available free mammography to large numbers of women, only 4.1% of our patients were diagnosed by mammograms. On the other hand, nearly 80% first noticed the tumor themselves. A later study published in 1981[9] again found that 80% of tumors were discovered by the patient. The inescapable conclusion is that if women are going to be the chief diagnosticians of breast cancer, we should try to teach them to improve their skills. A woman may never become as skillful at palpation of a tiny nodule as a physician, but she has the advantage of feeling internally as well as externally and of becoming familiar with the feel of her own breasts. She may notice a thickening or a discomfort — "something is different" — that brings her in for an examination. Women will do BSE when they will not have an annual physical examination and mammography. It is not a complete screening procedure, but it is a help.

There is the legitimate fear that the use of BSE might impart a false sense of security to a woman and lead her to defer more effective screening modalities. In the previous report of our study we showed that, on the contrary, women who practiced BSE were more likely to have mammography.

## Conclusions

1. Breast cancer is the most common cancer of women.
2. Significant improvement in the cure rate of breast cancer through the application of current knowledge is going to depend largely upon earlier diagnosis.
3. Until recent years, at least, most breast tumors are discovered by the patient.
4. Women who practice BSE are diagnosed at an earlier stage.
5. Women who practice BSE before developing breast cancer survive longer.
6. It is important to teach women to improve their skills in BSE and to motivate them to practice monthly.
7. BSE is not a substitute for annual physical examination and mammography but an effective complement.
8. Mammography is the most effective screening technique, and we must try to get all women in the target group to make it an annual practice.

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# The Surgical Management of Breast Cancer

*Ralph W. Powell, M.D.*

ABOUT 125 YEARS AGO, Sir Games Paget,[1] a surgical authority on breast cancer, wrote, "I am not aware of a single instance of recovery, that is, as that the patient should live for more than ten years free from the disease — in deciding for or against the removal of a cancerous breast in any single case, we may, I think, dismiss all hope that the operation will be the final remedy for the disease." Surgery for breast cancer at that time was crudely done, involving much blood loss and wound infection, with septicemia not uncommonly resulting in a fatality.

Halsted[2] and Willy Meyer[3] independently conceived and reported a new operation for breast cancer that had dramatic results — the so-called standard radical mastectomy. For example, Billroth's end results in 1878[4] were reported as 82 percent local recurrences and 4.7 percent clinical cures. In 1898 Halsted reported 3-year results in 76 cases, with a local recurrence rate of 10 percent and a clinical cure rate of 41 percent.[5] Most of these patients had advanced disease, with 79 to 90 percent having axillary node metastases.[6] Figure 1 shows the effect of this advanced disease on the 4-year survival of Halsted's patients and is compared with current survival data.

Radical mastectomy remained the gold standard of treatment of breast cancer for a half-century. Following World War II, probably related to dissatisfaction with surgical results, alternative treatment methods were suggested. McWhirter reported treatment results equal to the radical mastectomy with a simple mastectomy and postoperative x-ray therapy.[7] Ian McDonald challenged the Halstedian hypothesis of breast cancer by suggesting that it was biologically predetermined from onset.[8] This theory was a stimulus for less extensive surgical procedures. However, at the same time, more radical procedures were also reported, notably by Urban.[9] These more extensive surgical procedures gradually lost favor, partially due to the reports of x-ray therapy to local node bearing areas achieving similar results.

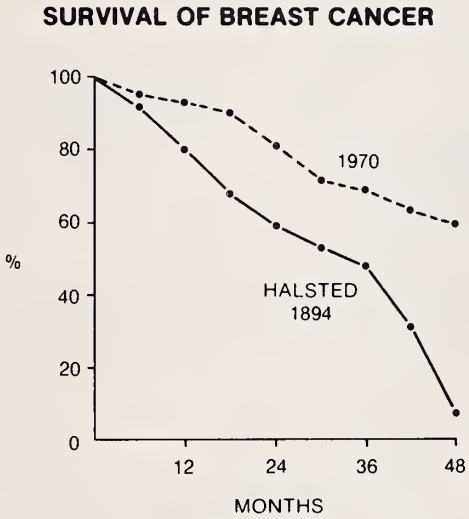


*Figure 1 — Life table analysis of Halsted's original cases compared to current survival data.*[55]

Over the past 40 years, probably due to earlier diagnosis, there has been a continuous trend toward conservatism in the surgical treatment of breast cancer. The standard radical mastectomy was gradually replaced by the Patey[38] modified radical mastectomy (or some modification).[39, 40] Before this modified procedure had been generally accepted, even more conservative treatment was introduced.[18, 32, 34, 35] As a result of these randomized clinical trials,[32, 34] treatment with breast conservation was found to offer selected patients results equal to those of a mastectomy. However, other clinical trials reported contrary findings.[33, 35] There are also divergent hypotheses of cancer spread.[41] Because of these differences, significant controversy still prevails regarding surgery for breast cancer.

The Halsted hypothesis held that breast cancer spreads in a centrifugal fashion to regional nodes and that distant spread was primarily by lymphatic permeation. The hematogenous spread was not felt to be significant. This implied that since lymph nodes act as barriers to cancer spread, the en bloc removal of the primary tumor and adjacent nodes could be curable. Therefore, the extent of the operation was positively related to the curability of the disease.[5]

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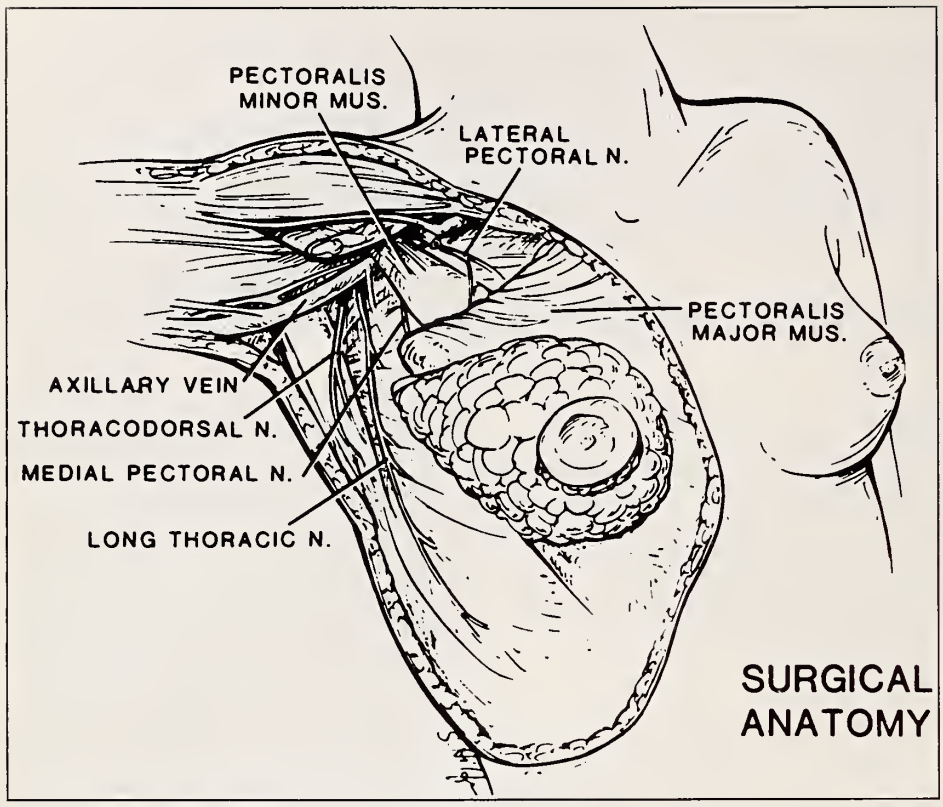


*Figure 2 — Surgical anatomy of the breast and axilla.*[56]

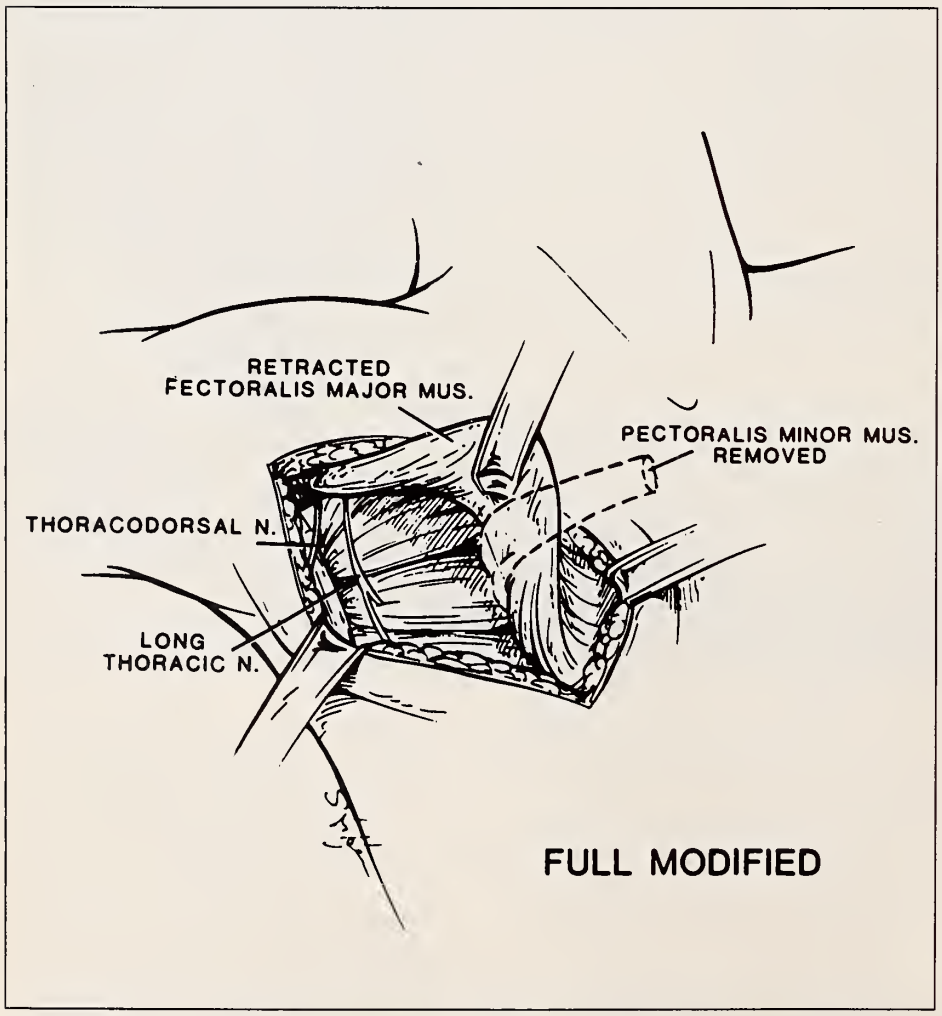


*Figure 3 — The Patey technique of full modified radical mastectomy.*[56]

The alternative hypothesis, advocated by Fisher,[19] emphasizes the hematogenous spread of the disease. The lymph nodes are indicators of the biologic behavior of the tumor cells and are not barriers to their spread. This implies that breast cancer is systemic from its inception. A further logical assumption is that loco-regional treatment is unlikely to affect survival. Therefore, only effective systemic therapy would improve treatment results.

Reports by Adair and Koscielny that an increasing tumor diameter adversely affects survival is contrary to the theory of biologic predeterminism.[20,21] Two clinical trials of screening are also contrary to this hypothesis. The Health Insurance Plan of Greater New York[22] found that the mortality of breast cancer could be reduced by one-third in a population offered screening. The other screening trial from the Swedish National Board of Health[23] showed a statistically significant reduction in breast cancer mortality in a screened population without contribution from lead time or length bias. These data suggest strongly that the disease is not always initially systemic.

The curability of breast cancer is controversial, for which the use of different definitions of cure is largely responsible. In clinical practice, the measure of survival over a fixed period of time is more practical. However, a comparison of survival of the treated population with a matched unaffected group is probably more accurate. Survival curve of patients treated in Cambridge, England, suggests that after 10 years the force of mortality from breast cancer begins to parallel that of the normal age matched population.[45] Another report by Harris and Hellman which re-analyzed two large series of patients had similar findings.[24] A differing report by Mueller and Jeffries[25] found an exponential survival pattern in breast cancer and concluded that treatment affects neither the cause nor the time of death. These divergent reports are representative of many others in the literature. These differing hy-

potheses regarding the natural history of the disease and opposite findings regarding curability create considerable confusion. One explanation for these differences is that both host and tumor are heterogeneous.

Most of the reported treatment results with long follow-up times are retrospective studies using survival over a fixed time as defining a cure[12-15] and are considered anecdotal by some authorities.[17] Randomized clinical trials are superior with selection bias minimized. Even these studies have problems. In breast cancer, large numbers of patients are required, since treatment differences may be small. This requires the participation of multiple research centers in which the clinical and operative acumen as well as the genetic and environmental conditions are all variable. For example, in the NSAB-06 trial, 89 participating institutions required almost 8 years to enroll 2163 patients. This contribution of 3 patients per institution per year obviously represents only a small portion of the total breast cancer cases seen and treated. This potential selection bias recently prompted three articles and an editorial in the *New England Journal of Medicine* regarding a randomized trial to evaluate cranial arterial by-pass surgery.[54] Despite these problems, much worthwhile information has become available.

In the NSAB-04 trial,[34] radical mastectomy was compared with total mastectomy with and without x-ray therapy. At 10 years, there was no significant difference between disease-free and overall survival in the treatment groups. A very interesting finding was in the clinically node-negative group treated with mastectomy alone in which a 40 percent incidence of occult axillary metastasis was expected and only 18 percent had axillary recurrence. This infers that all node metastases are not obligated to become clinically apparent. In a similar randomized trial from Great Britain (Kings/Cambridge trial),[31] there was a significantly greater local recurrence rate in the group treated with total mastectomy alone than in those

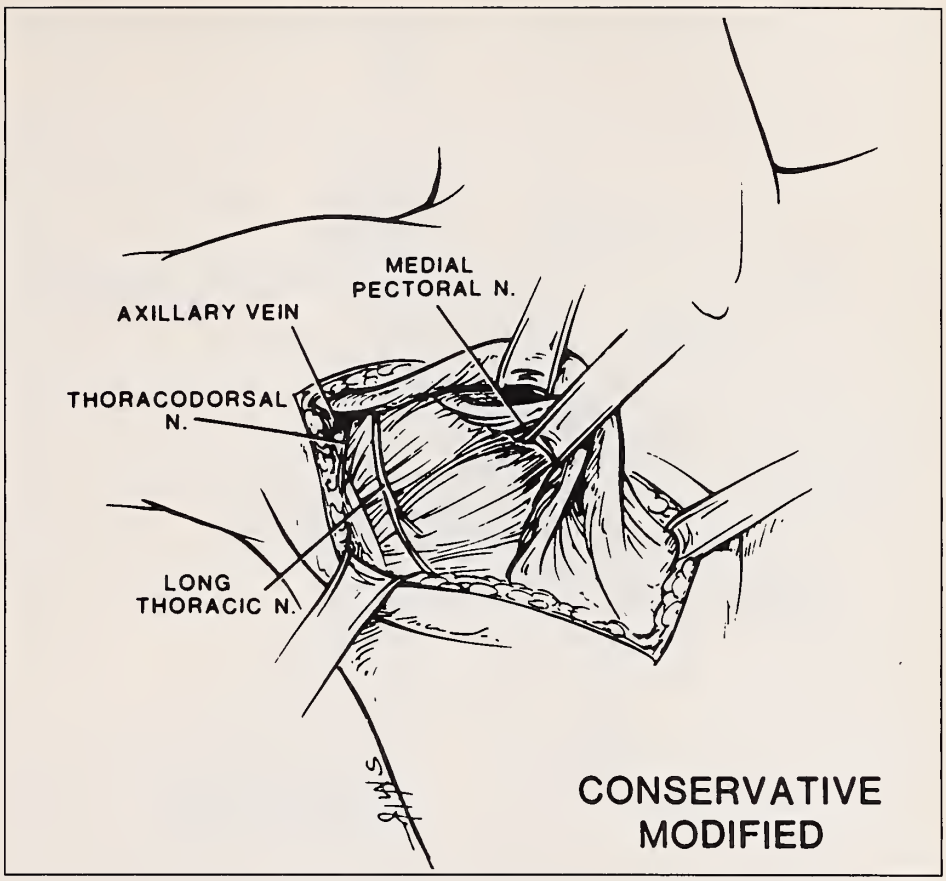


*Figure 4 — The conservative radical mastectomy of Madden and Auchincloss.*[56]

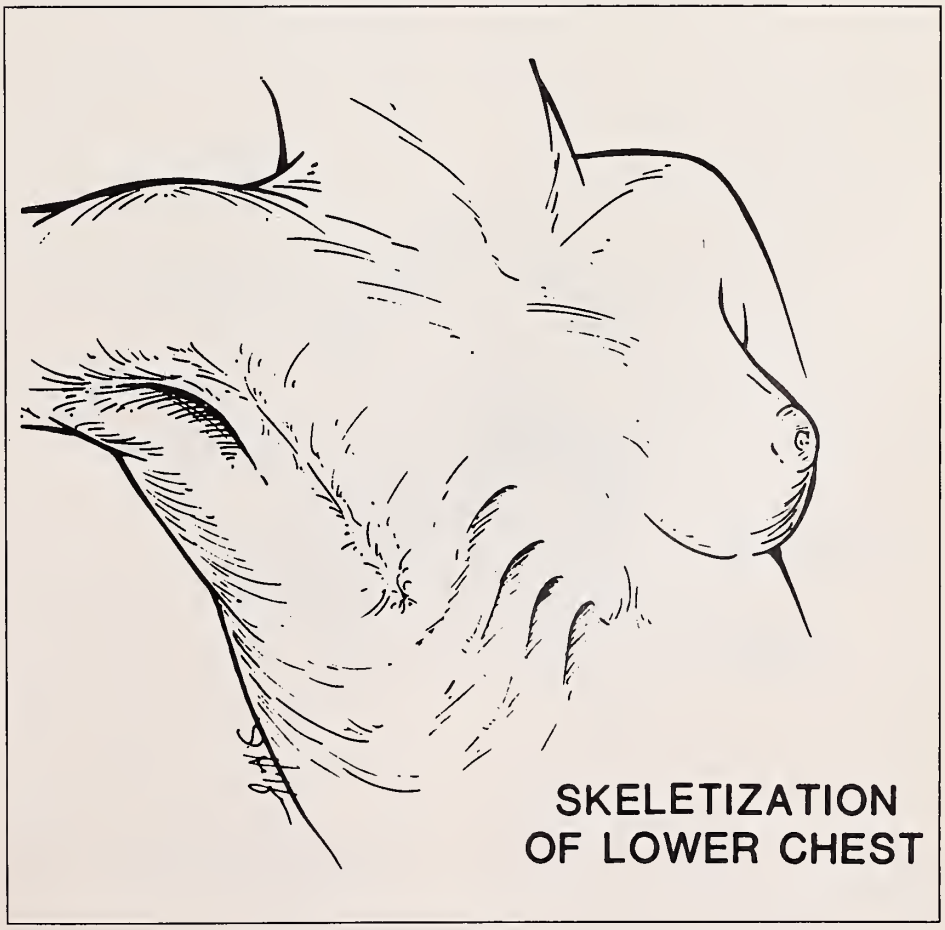


*Figure 5 — Skeletonization of the chest wall due to removal of both pectoral nerves.*[56]

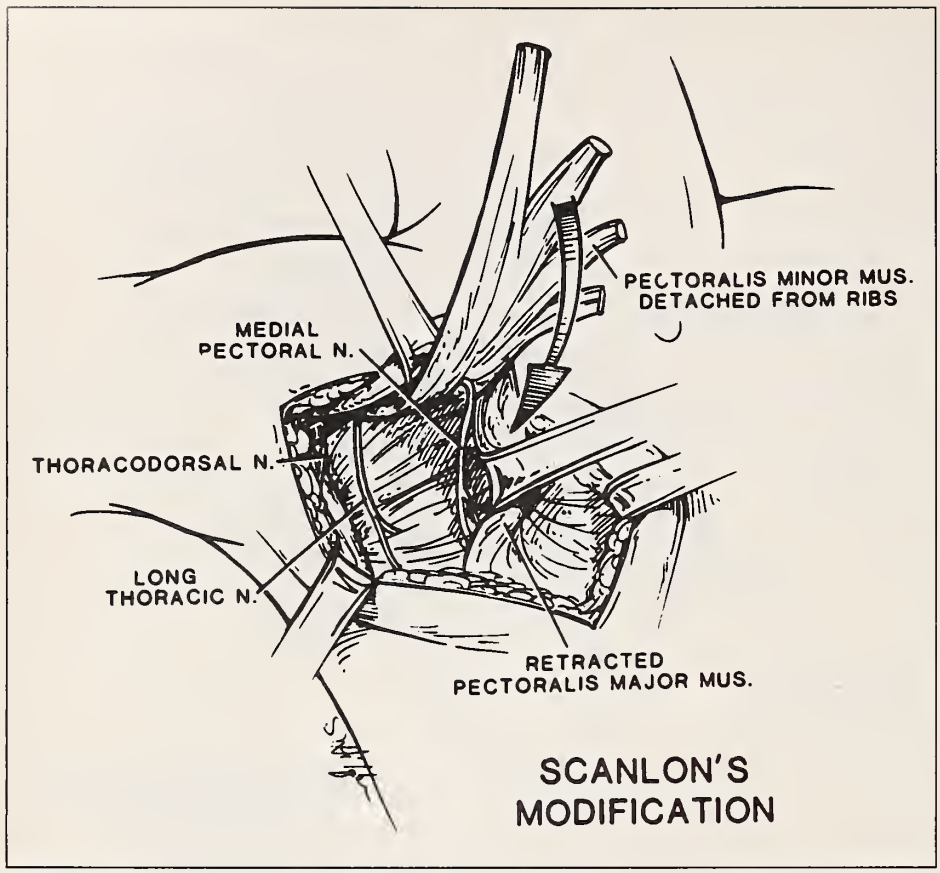


*Figure 6 — Scanlon's modification of the conservative modified radical mastectomy.*[56]

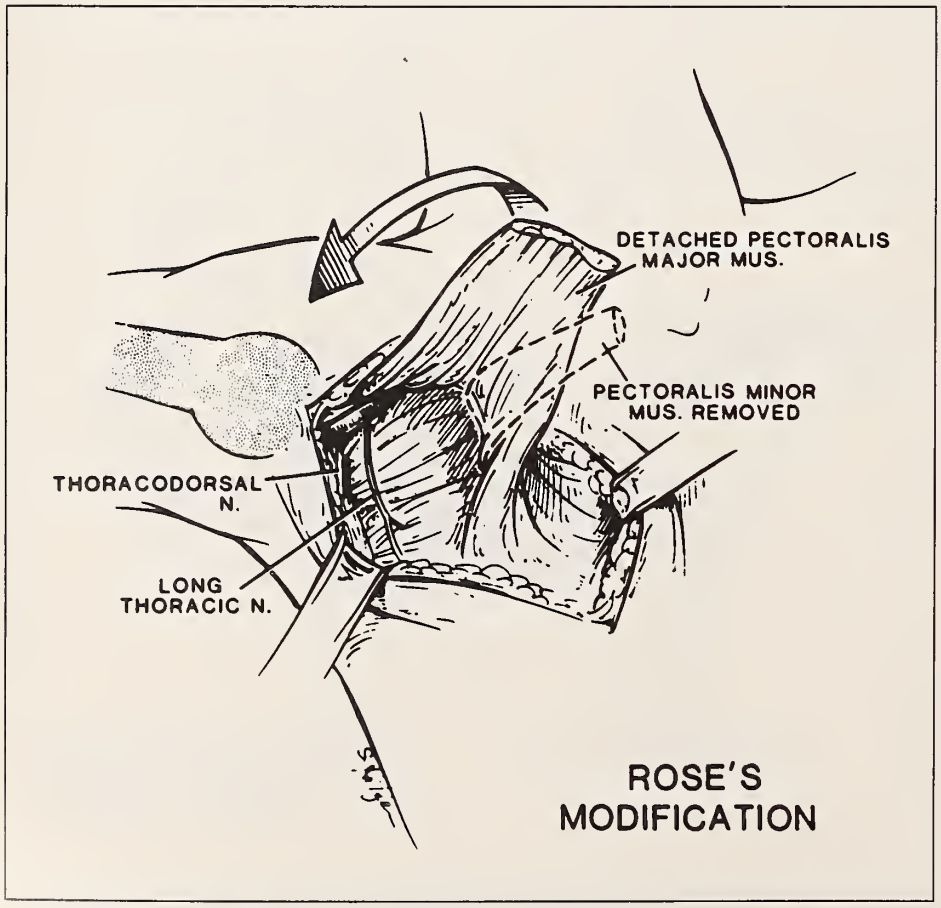


*Figure 7 — Roses' modification of the conservative radical mastectomy.*[56]

treated with total mastectomy and x-ray therapy. However, the overall survival was the same in both groups over a 9 to 14 year period.

The Milan, Italy, study randomized over 700 patients to a radical mastectomy or quadrant resection, full axillary dissection and x-ray therapy.[32] There was no significant difference in survival between the two groups over 3.5 years median follow up. The extremely low (0.6%) local recurrence reported in both groups causes concern about the accuracy of the follow up. Differing results are reported in a clinical trial from Scotland of about 500 patients.[33] In this trial, the total mastectomy with post-operative x-ray therapy group had a significantly worse survival rate compared to the radical mastectomy group. The difference was mainly in Stage I patients.

The NSAB-06 trial,[17] randomized 1843 Stage I & II breast cancer patients into groups that were treated with total mastectomy and axillary dissection versus segmental mastectomy and axillary dissection with or without radiation therapy. There was no significant difference in survival in any of the treatment groups. Although the non-irradiated segmentectomy group had a three-fold higher (28%) local recurrence rate than the x-ray therapy group, the overall survival was not adversely affected. In this trial, the non-irradiated segmentectomy with negative axillary nodes had a significantly worse distant disease-free survival rate (72.8%) than the segmentectomy with x-ray therapy group (82.5%). This suggests that long-term survival also may be adversely affected.

The above findings are partially similar to the Guys Hospital trial comparing radical mastectomy to partial mastectomy and x-ray therapy (3800 R) without axillary dissection.[35] In this trial, there was a significantly higher local recurrence rate, a lower disease-free survival rate, and increased death rate in the partial mastectomy x-ray therapy group when compared to the radical mastectomy group. This increased death rate is contrary to the

results of the B-06 protocol, although there are major differences in the design of the two trials. The lower survival rate in the Guys Hospital trial may be due to a longer follow-up time than in the B-06 trial. If this difference is related to the lower irradiation dose in the London trial, one can conclude that loco-regional failure adversely influenced survival.

Traditionally, the justification for mastectomy is because multicentric breast cancer has been assumed to be of clinical significance. This implies that untreated foci of breast cancer will eventually multiply and potentially affect curability. The reported incidence and biologic significance of multicentricity of breast cancer has been questioned.[26] Whole organ sectioning reported by Gallager has revealed a multicentric incidence of 74 percent.[27] The much lower incidence of multicentricity (13.4%) reported by Fisher et al[26] is probably due to the lesser extent of examination of residual breast tissue following mastectomy (a random sample of each quadrant). Several documented reports have shown that quadrant removal or wide local excision without radiation therapy has resulted in local recurrence rates of 19 to 37 percent.[28,29] This agrees with findings of Fisher NSAB-06 trial which had a 28 percent local recurrence rate in patients treated with segmentectomy and axillary dissection without x-ray therapy at 39 months follow-up time.[17] Since patients in the B-06 trial with cancer at the surgical margins were treated by mastectomy (10% of total), it would seem that free surgical margins are inadequate and that untreated multifocal or multicentric microscopic disease in the adjacent tissue does progress to clinically significant disease in the breast that is not treated by x-ray therapy or surgery.

The ability of x-ray therapy to prevent the multifocal or multicentric disease from evolving into clinically detectable cancer is one of the main issues in the current controversy concerning treatment. In a report (1984) by Osborne et al[30] from the Royal Marsden Hospital in London of 263 patients with Stage I & II disease treated by wide local excision and x-ray therapy and followed 10 to 20 years, 50% of the loco-regional failures occurred after 5 years. Similar long-term loco-regional recurrences in patients treated with and without limited surgery and x-ray therapy have been reported by Amalric et al[46] from the Marseilles Cancer Institute (41% of the loco-regional recurrence found between year 5 and 10) and from the Princess Margaret Hospital in Toronto by Clark and coworkers[53] (47% of the loco-regional failures occurred between year 5 and 10). These findings are in sharp contrast to the loco-regional recurrence pattern after mastectomy, because the majority of these failures occur in the first few post-operative years. Therefore, if increased local recurrence rates have any impact on survival, this may not be detected until 15 to 20 years of follow up. A primary advantage of breast conservation is lost in the group of patients who have local recurrence, since mastectomy is then the usual treatment. Because of prior irradiation, an increase in wound complications in the group in whom local recurrence develops can be expected. For the same reason, breast reconstruction will be more difficult and less satisfactory. Therefore, maximum local control of disease should be a major goal of those treating breast cancer, even though the influence on the natural history of the disease is debatable.[41]

*The Halsted hypothesis held that breast cancer spreads in a centrifugal fashion to regional nodes and that distant spread was primarily by lymphatic permeation.... The alternative hypothesis, advocated by Fisher, emphasizes the hematogenous spread of the disease.*

The three usual locations of loco-regional recurrence in breast cancer are parasternal, axillary, and chest wall. The average local recurrence rate in the chest wall from a cooperative study with comparable stages of disease after 10 years follow up in patients treated by total or radical mastectomy is between 10 and 15 percent. When parasternal and axillary recurrence are added, the combined recurrence rate is between 20 and 25 percent.[13] Historically, chest wall recurrence after mastectomy was blamed on the surgeon — either poor technique or on poor patient selection (advanced disease).[13] Many reports[37] have a 5% or less 5-year survival after chest wall recurrence following mastectomy, although the survival after parasternal and axillary recurrence is somewhat better. Contrary to these results, salvage mastectomy with 5-year survival after recurrence following segmentectomy, axillary dissection, and x-ray therapy is reported to be above 50%.[18,46] A reasonable explanation for this impressive survival difference is that local recurrence after mastectomy is usually (not always) an indicator of disseminated disease; whereas local recurrence after breast conservation is actually persistent disease — either locally persistent or multifocal or multicentric that has become clinically apparent. Thus, it seems reasonable to assume that persistent disease that becomes recognizable can be more successfully treated than truly recurrent breast cancer. However, a long follow-up time of the locally recurrent group after breast conservation may show a smaller difference in survival between the two groups.

X-ray therapy to the residual breast tissue is an essential part of breast conservation treatment, although some groups (notably The Cleveland Clinic) do not routinely follow this protocol.[48]

*Most of the reported treatment results with long follow up times are retrospective studies using survival over a fixed time as defining a cure and are considered anecdotal by some authorities. Randomized clinical trials are superior with selection bias minimized.*

Therefore, the risk of x-ray carcinogenesis deserves comment. Many reports[49-51] have found an increased incidence of breast cancer following irradiation of the female breast. All of these lack a control group, which leads to uncertainty in reaching conclusions. However, the report from the Radiumhemmet, Stockholm, Sweden, is noteworthy. In 1115 women treated with x-ray for several non-malignant conditions of the breast, there was a fourfold increase of observed to expected breast cancers in the irradiated group. The finding that the observed incidence of breast cancer in the irradiated breast was sixfold higher than in the non-irradiated side suggests some connection between irradiation and subsequent breast cancer in this group of patients. Our physicist has measured the radiation to the opposite breast in breast conservation patients.[52] These results suggest a slight increase in breast cancer risk in the irradiated group over the natural incidence rate in long-term survivors using information from the 1980 BEIR Committee report. None of the above information is sufficient to conclude that x-ray therapy in breast conservation will increase the incidence of cancer in either breast. However, the recognition of small differences in the incidence of breast cancer in the opposite side will probably require a 20 year follow-up period.

**Surgical Techniques**

The modified radical mastectomy is currently the most commonly used surgical treatment for breast cancer[44] (Figure 2). The Patey procedure[38] (Figure 3) involves removal of the pectoralis minor muscle and sacrifice of the medial pectoral nerve. Level I, II, and III of the axilla are removed. The conservative modified radical mastectomy reported by Madden[39] (Figure 4) and Auchincloss[40] involves retracting the pectoralis minor muscle and removing Level I and most of Level II nodes, but usually with preservation of both pectoral nerves. The preservation of both pectoral nerves avoids skeletization of the chest wall caused by atrophy of the pectoralis major muscle (Figure 5). When the mid-axilla nodes are enlarged and suspect, modifications of these modified radical mastectomies have been described and may be beneficially employed with preservation of both pectoral nerves. Scanlon's technique (Figure 6) salvages the medial pectoral nerve by dividing and resuturing the three slips of origin of the pectoral minor. This allows full axillary dissection. Roses' modification (Figure 7) includes dividing and resuturing the pectoralis major muscle near its insertion. Hayward, one of the staunchest advocates of the full axillary dissection, states that staging is a primary reason for this procedure.[35] In our clinical practice, we have utilized the conservative radical mastectomy for 20 years. With this procedure, the average number of nodes found per specimen is 18 to 20, although this may vary with the diligence of the prosector. If, at surgery, significant adenopathy is found extending posteriorly to the pectoralis minor muscle or in Rotter's space, we have employed either the Patey procedure or Roses' modification of the conservative radical mastectomy. From this experience, the incidence of axillary recurrence has not been sufficient (less than 0.2%) to alter this method of management.

In breast conservation surgery, the two methods of treatment of the breast are quadrantectomy or segmentectomy. The quadrant excision removes more breast tissue than segmentectomy and is performed when possible with an incontinuity removal of the breast tissue and axillary nodes.[32] Segmentectomy is cosmetically oriented, and the incision is usually circumferential in the Lines of Langer. Cancer-free surgical margins are desired, but as recently noted by Carter,[47] this may be difficult to verify by frozen section. After the surgical margins are found to be clear of cancer, a separate transverse axillary incision is used for the node dissection. When quadrantectomy is performed with incontinuity node removal, the lower axilla is more thoroughly removed. However, the separate transverse axillary incision is cosmetically superior.

As in modified mastectomy, the extent of axillary dissection in breast conservation surgery is controversial. Advocates of full axillary dissection removed the pectoralis minor and the medial pectoral nerve as in the Patey modified mastectomy. The conservative axillary dissection, which is commonly used, retracts the minor muscle and removes Level I and either all or part of Level II and none of Level III.

In the two recently reported randomized trials,[32, 34] Veronesi's group employed quadrant removal with full axillary dissection, whereas the NSAB-06 protocol did not require a full dissection and emphasized cosmesis for the segmentectomy.

**Summary and Conclusions**

1. Breast cancer has not been proven to be a systemic disease from its inception.
2. Loco-regional recurrent disease may act as a source of tertiary spread.
3. Breast conservation has a greater loco-regional recurrence rate than total mastectomy.
4. Whether the loco-regional failures after conservation therapy can be salvaged with expected survival similar to total mastectomy patients is a key question. The two largest randomized trials with about 3.5 years follow up

have answered this question affirmatively.

5. With proper patient selection, segmentectomy, axillary dissection, and x-ray therapy is a valid choice of treatment of invasive breast cancer.

On the basis of this information, it is reasonable to conclude that there is no one treatment method of breast cancer that gives the best results. As of this time, it is clearly unwise to totally abandon mastectomy with known results in favor of a lesser procedure with treatment results that have not been clearly established. It is not surprising that there are an increasing number of women with breast cancer who justifiably demand to participate in the therapeutic decision after having been informed of the treatment options. Before a final decision is reached, the following reasons for caution should be made clear. The reported results in clinical trials apply to patients with Stage I & II disease. Therefore, all patients with operable breast cancer are not candidates for breast conservation. The length of follow up of these clinical trials is well under 10 years; these reported results may change. The risk of delayed (10-30 years) irradiation carcinogenesis in the treated as well as the opposite breast is not clear. However, of great psychologic importance and its contribution to the quality of their lives is the knowledge that all women with breast cancer do not require a mastectomy for a chance of cure. This is a valuable tool to encourage women to practice breast self-examination, to obtain mammograms regularly, and to seek medical advice promptly when breast symptoms occur.[37]

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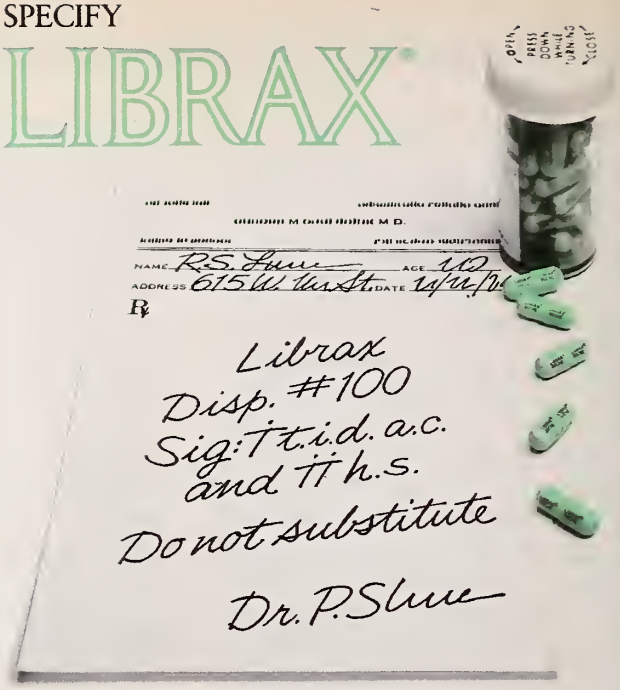


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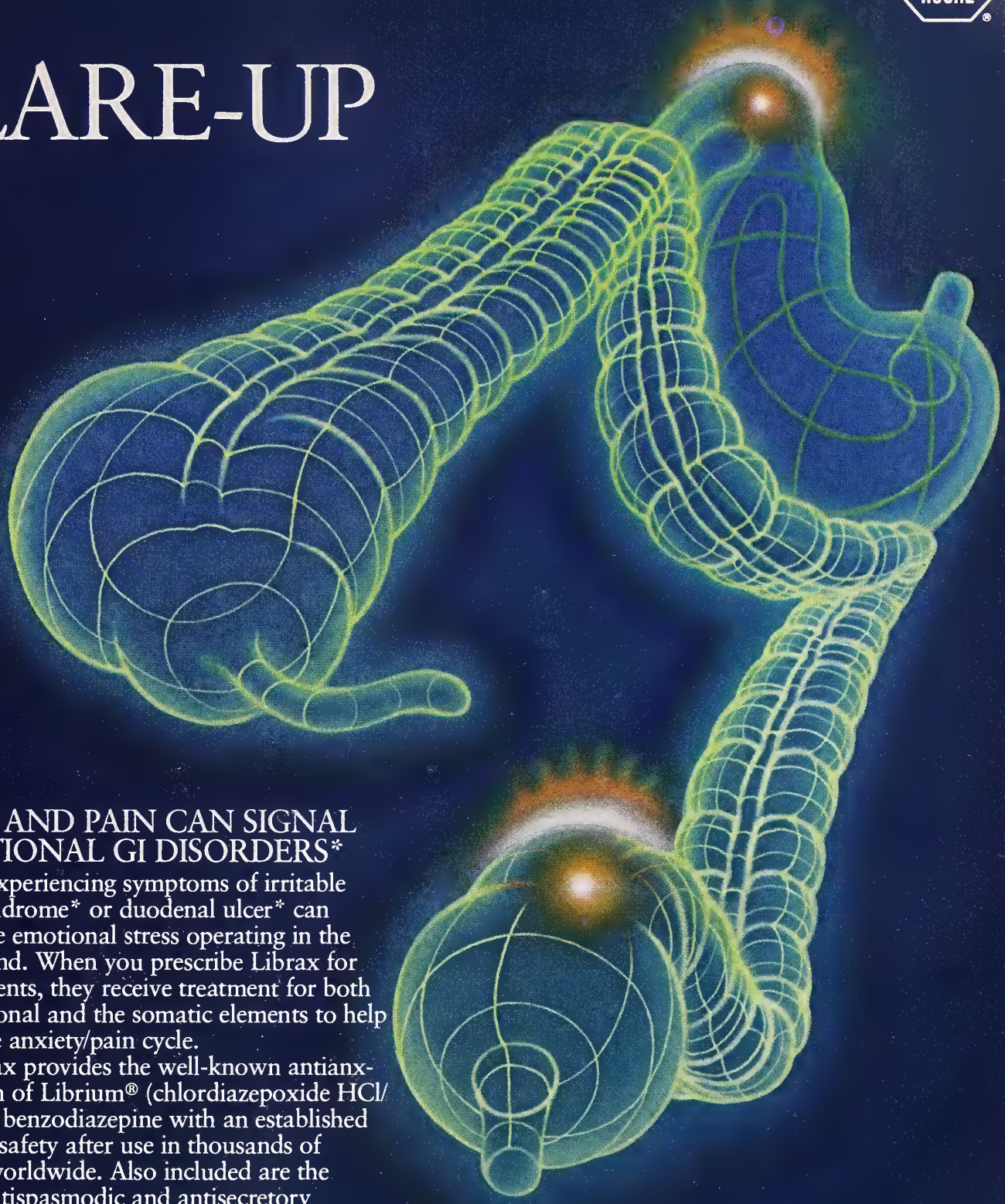

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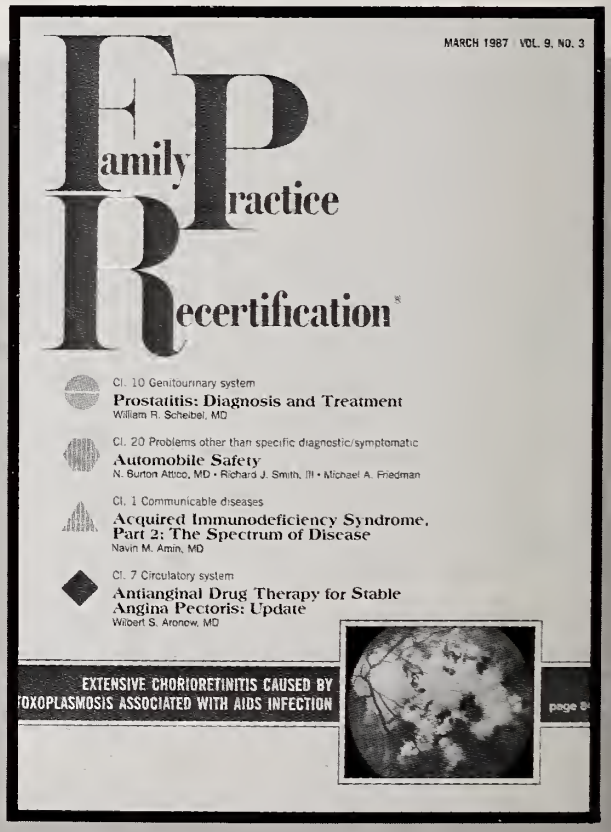


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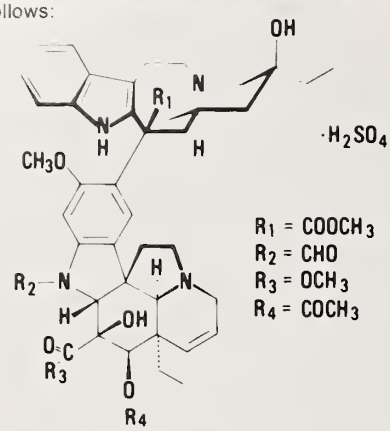


Each ml contains vincristine sulfate, 1 mg; mannitol, 100 mg; methylparaben, 1.3 mg; propylparaben, 0.2 mg; water for injection, q.s. Acetic acid and sodium acetate have been added for *p*H control. The *p*H of Oncovin Solution ranges from 3.5 to 5.5.

**Action:** The mode of action of Oncovin is unknown but is under investigation. Treatment of neoplastic cells in vitro with Oncovin demonstrated that it may cause an arrest of mitotic division at the stage of metaphase.

Central-nervous-system leukemia has been reported in patients undergoing otherwise successful therapy with Oncovin. This suggests that Oncovin does not penetrate well into the cerebrospinal fluid.

**Indications:** Oncovin is indicated in acute leukemia.

It has also been shown to be useful in combination with other oncolytic agents in Hodgkin's disease, lymphosarcoma, reticulum-cell sarcoma, rhabdomyosarcoma, neuroblastoma, and Wilms' tumor.

**Contraindications:** There are no contraindications to the use of Oncovin, but careful attention should be given to those conditions listed under Warnings and Precautions.

**Warnings: This preparation is for intravenous use only. The intrathecal administration of Oncovin is uniformly fatal.**

Since reproduction studies have not been performed in animals, there is insufficient information as to whether this drug may affect fertility in men and women or have teratogenic or other adverse effects on the fetus. The physician should weigh the benefits in relation to the risks when using this and other chemotherapeutic agents in populations in which reproduction may be a factor.

**Precautions:** Acute uric acid nephropathy, which may occur after the administration of oncolytic agents, has also been reported with Oncovin. In the presence of leukopenia or a complicating infection, administration of the next dose of Oncovin warrants careful consideration.

If central-nervous-system leukemia is diagnosed, additional agents may be required, since Oncovin does not appear to cross the blood-brain barrier in adequate amounts.

Particular attention should be given to dosage and neurologic side effects if Oncovin is administered to patients with preexisting neuromuscular disease and also when other drugs with neurotoxic potential are being used.

Acute shortness of breath and severe bronchospasm have been reported following the administration of vinca alkaloids. These reactions have been encountered most frequently when the vinca alkaloid was used in combination with mitomycin-C. The onset may be within minutes or several hours after the vinca is injected.

**Adverse Reactions:** In general, adverse reactions are reversible and are related to dosage. The most common adverse reaction is hair loss; the most troublesome are neuromuscular in origin.

When single weekly doses of the drug are employed, the adverse reactions of leukopenia, neuritic pain, constipation, and difficulty in walking are usually of short duration (i.e., less than seven days). When the dosage is reduced, these reactions may lessen or disappear. They seem to be increased when the calculated amount of drug is given in divided doses. Other adverse reactions, such as hair loss, sensory loss, paresthesia, slapping gait, loss of deep-tendon reflexes, and muscle wasting, may persist for at least as long as therapy is continued. In most instances, they have disappeared by about the sixth week after discontinuance of treatment, but in some patients the neuromuscular difficulties may persist for prolonged periods.

In addition to constipation (mentioned below), paralytic ileus may occur, particularly in young children. The ileus will reverse itself upon temporary discontinuance of Oncovin and with symptomatic care. It mimics the "surgical abdomen."

Frequently, there is a sequence in the development of neuromuscular side effects. Initially, only sensory impairment and paresthesias may be encountered. With continued treatment, neuritic pain may appear and, later, motor difficulties. No reports have yet been made of any agent that can reverse the neuromuscular manifestations accompanying therapy with Oncovin.

Convulsions, frequently with hypertension, have been reported in a few patients receiving Oncovin.

Rare occurrences of the syndrome attributed to inappropriate antidiuretic hormone secretion have been observed in patients treated with Oncovin. The syndrome has been described in association with several disease states. There is high urinary sodium excretion in the presence of hyponatremia; renal or adrenal disease, hypotension, dehydration, azotemia, and clinical edema are absent. With fluid deprivation, improvement occurs in the hyponatremia and in the renal loss of sodium.

Constipation may take the form of upper-colon impaction, and, on physical examination, the rectum may be found to be empty. Colicky abdominal pain coupled with an empty rectum may mislead the physician. A flat film of the abdomen is useful in demonstrating this condition. All cases have responded to high enemas and laxatives. A routine prophylactic regimen against constipation is recommended for all patients receiving Oncovin.

Other adverse reactions that have been reported are abdominal cramps, ataxia, foot drop, weight loss, optic atrophy with blindness, transient cortical blindness, fever, cranial nerve manifestations, paresthesia and numbness of the digits, polyuria, dysuria, oral ulceration, headache, vomiting, diarrhea, and intestinal necrosis and/or perforation.

Oncovin does not appear to have any constant or significant effect on the platelets or the red blood cells. Thrombocytopenia, if present when therapy with Oncovin is begun, may actually improve before the appearance of marrow remission.

**Dosage and Administration: This preparation is for intravenous use only (see Warnings).**

**Extreme care must be used in calculating and administering the dose of Oncovin, since overdosage may have a very serious or fatal outcome.**

The drug is administered intravenously at *weekly intervals*. The usual dose of Oncovin for children is 2 mg/m²; for adults, 1.4 mg/m². Various dosage schedules have been used (see package literature for references).

The solution may be injected either directly into a vein or into the tubing of a running intravenous infusion. Injection of the Oncovin may be completed in about one minute.

*Caution—It is extremely important that the needle be properly positioned in the vein before any vincristine is injected. If leakage into surrounding tissue should occur during intravenous administration of Oncovin, it may cause considerable irritation. The injection should be discontinued immediately, and any remaining portion of the dose should then be introduced into another vein. Local injection of hyaluronidase and the application of moderate heat to the area of leakage help disperse the drug and are thought to minimize discomfort and the possibility of cellulitis.*

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit.

**Overdosage:** Side effects following the use of Oncovin are dose related. Therefore, following administration of an overdose, patients can be expected to experience side effects in an exaggerated fashion. Supportive care should include the following: (1) prevention of side effects resulting from the syndrome of inappropriate secretion of antidiuretic hormone (this would include restriction of fluid intake and perhaps the administration of a diuretic affecting the function of the loop of Henle and the distal tubule); (2) administration of anticonvulsant doses of phenobarbital; (3) use of enemas to prevent ileus (in some instances, decompression of the gastrointestinal tract may be necessary); (4) monitoring the cardiovascular system; and (5) determining daily blood counts for guidance in transfusion requirements.

Folinic acid has been observed to have a protective effect in normal mice which were administered lethal doses of Oncovin (Cancer Res., *23:*1390, 1963). Isolated case reports suggest that folinic acid may be helpful in treating humans who have received an overdose of Oncovin. A suggested schedule is to administer 15 mg of folinic acid intravenously every three hours for 24 hours and then every six hours for at least 48 hours. Theoretical tissue levels of Oncovin derived from pharmacokinetic data are predicted to remain significantly elevated for at least 72 hours. Treatment with folinic acid does not eliminate the need for the above-mentioned supportive measures.

**How Supplied:** Vials Oncovin® Solution (vincristine sulfate injection, Lilly), 1 mg/1 ml, 2 mg/2 ml, and 5 mg/5 ml.

Hyporets® (disposable syringes, Lilly), Oncovin Solution, 1 mg/1 ml and 2 mg/2 ml. [101185]

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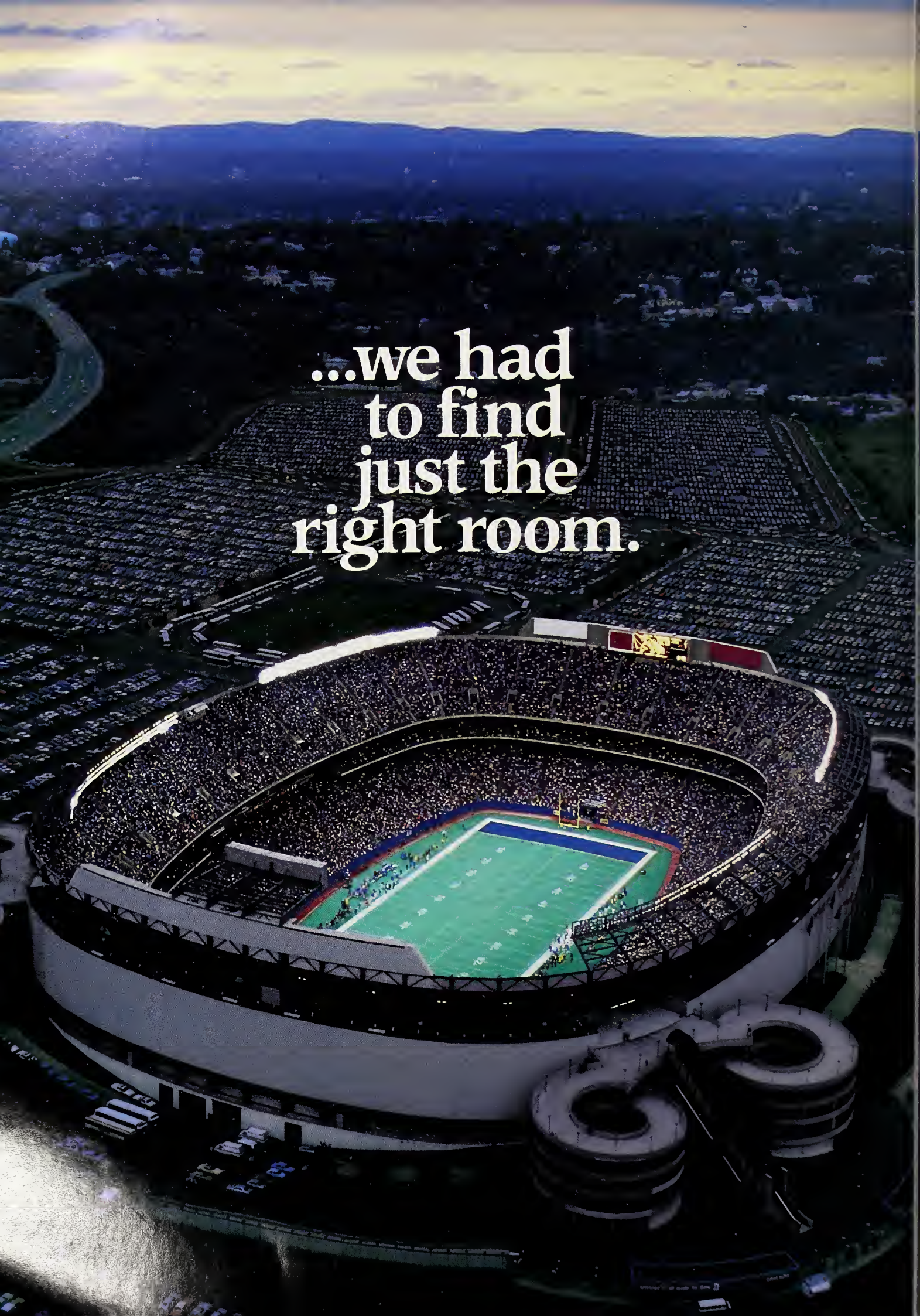
# To show you how many hypertensives stayed on

# INDERAL® LA
(PROPRANOLOL HCl)

# after a major nationwide trial...


...we had
to find
just the
right room.

# 60,073 patients (90%) who started on INDERAL® LA stayed on INDERAL LA.[1*]

## Surprising? Not really.

Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.
A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients[2] revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol—which shows how well-tolerated once-daily INDERAL LA can be.

## Sole therapy or concomitant therapy? Fifty-nine percent of the time, INDERAL LA stood on its own.

The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were treated merely with the addition of a diuretic to INDERAL LA.

## For the noncompliant patients in your practice, INDERAL LA may well be the answer.

Almost 20,000 of the patients in the nationwide compliance trial were identified as having been noncompliant with their previous antihypertensive therapy. Their physicians reported that 88% showed improved compliance when placed on once-daily INDERAL LA.

# Control, comfort, and compliance

ONCE-DAILY
**INDERAL® LA**
(PROPRANOLOL HCl)
LONG ACTING CAPSULES

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

# The one you know best keeps looking better

NOW AVAILABLE...
NEW LOW DOSE
INDERAL LA 60 mg
LONG ACTING CAPSULES
(PROPRANOLOL HCl)

Please see next page for brief summary of prescribing information.

# The one you know best keeps looking better

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

**INDERAL® LA** brand of propranolol hydrochloride **(Long Acting Capsules)**

**DESCRIPTION.** INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

**CLINICAL PHARMACOLOGY.** INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

**INDICATIONS AND USAGE. Hypertension:** INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

**Angina Pectoris Due to Coronary Atherosclerosis:** INDERAL LA is indicated for the long-term management of patients with angina pectoris.

**Migraine:** INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

**Hypertrophic Subaortic Stenosis:** INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

**CONTRAINDICATIONS.** INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

**WARNINGS.** CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

**Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)**—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing $T_4$ and reverse $T_3$, and decreasing $T_3$.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

**PRECAUTIONS.** GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

*Aluminum hydroxide gel* greatly reduces intestinal absorption of propranolol.

*Ethanol* slows the rate of absorption of propranolol.

*Phenytoin, phenobarbitone,* and *rifampin* accelerate propranolol clearance.

*Chlorpromazine,* when used concomitantly with propranolol, results in increased plasma levels of both drugs.

*Antipyrine* and *lidocaine* have reduced clearance when used concomitantly with propranolol.

*Thyroxine* may result in a lower than expected $T_3$ concentration when used concomitantly with propranolol.

*Cimetidine* decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

*Theophylline* clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS.** Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

*Cardiovascular:* Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

*Central Nervous System:* Light-headedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

*Gastrointestinal:* Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

*Allergic:* Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

*Respiratory:* Bronchospasm.

*Hematologic:* Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

*Auto-Immune:* In extremely rare instances, systemic lupus erythematosus has been reported.

*Miscellaneous:* Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

**DOSAGE AND ADMINISTRATION.** INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

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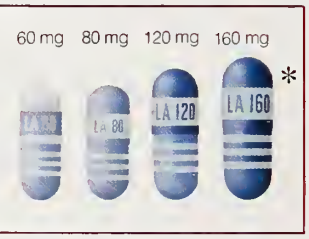
(PROPRANOLOL HCl)

LONG ACTING CAPSULES




**REFERENCES:**


1. INDERAL LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985; 145:1321-1323.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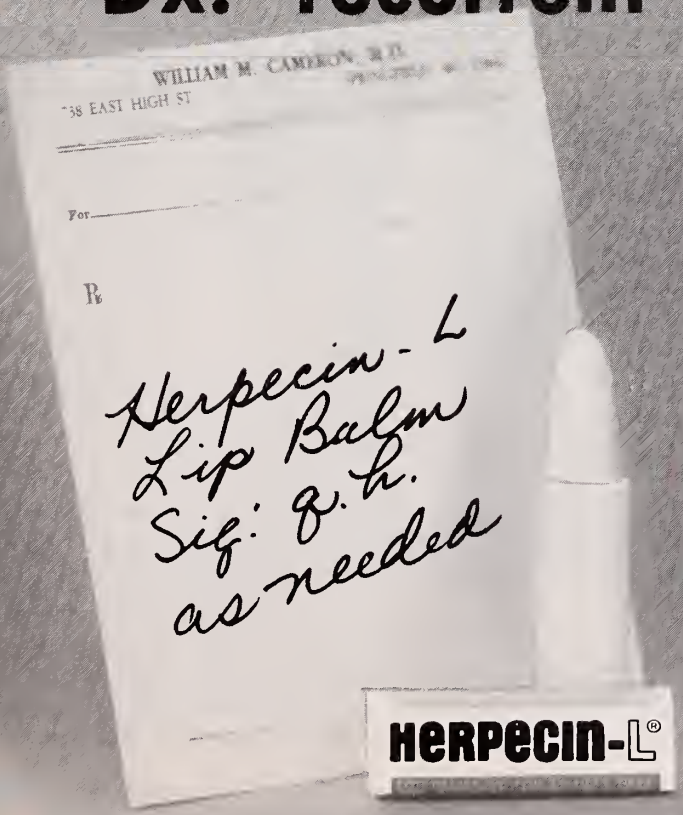


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# BREAST RECONSTRUCTION FOLLOWING MASTECTOMY

*Carl R. Hartrampf, Jr., M.D.*
*Paul W. Black, M.D.*
*Philip H. Beegle, Jr., M.D.*

THE FEAR OF MASTECTOMY is so pervasive and generates such underlying anxiety in women that it has understandably influenced opinions and actions regarding the diagnosis and treatment of breast cancer. This fear has been identified by some as one cause of delayed diagnosis of the disease, resulting in decreased chances of survival. When actually faced with breast cancer, the dread of losing a breast without hope of a reasonable reconstruction has motivated some women to insist on a breast-sparing mode of treatment, when in some cases the best chance of cure may be a mastectomy. Understanding these feelings, physicians who treat patients with breast cancer and those who reconstruct the breast after mastectomy are charged with new responsibilities to the patient.

All physicians treating patients with breast cancer have an obligation to speak enthusiastically about breast reconstruction at the time they inform their patients of the methods available for treatment of the disease. Not every woman with breast cancer is a candidate for reconstruction, and some women honestly have no desire for it, but all should be presented with the facts on reconstructive options early in the course of their treatment. The physician should present this information in such a way as to assuage the guilt sometimes associated with the inner desire to have the breast restored. Physicians should help their patients understand that the desire for reconstruction is a wholesome, natural feeling and reconstruction is simply an extension of the total treatment of their disease.

The reconstructive surgeon must be able to offer the mastectomy patient a breast reconstruction that is safe, has a natural appearance, is soft, and is trouble free over a lifetime. Once of questionable advisability, breast reconstruction is now a realistic option, due mainly to major advances in tissue transfer and new designs in alloplastic implants which have evolved in the last decade.

### Informing the Patient and Choosing the Method of Reconstruction

Women with breast cancer should be encouraged to seek the help of support groups such as those offered by the American Cancer Society. Talking to another individual who has experienced mastectomy and reconstruction is reassuring and moderates anxiety. In addition, there is informative reading for the patient in the book entitled *A Woman's Decision* by Berger and Bostwick. All reconstructive options should be explained to the patient, including indications and contraindications, and advantages and drawbacks to each procedure. Fortunately, there are a number of reasonable reconstructive options available. The choice of the method to be used should be made by balancing the patient's needs and desires with the procedures' indications and contraindications in her individual situation. Patients will need help in identifying what is a realistic goal in their case.

### Timing of the Reconstruction

There is no ideal time interval between mastectomy and reconstruction that can apply to every patient. The time for reconstruction will vary with the stage of disease, the desires of the patient, and the judgment of the surgeon. There is no evidence that breast reconstruction adversely influences the survival of breast cancer patients or that it masks chest wall recurrence.[1] In Stage I disease, therefore, there is no reason to delay reconstruction beyond the healing of the mastectomy wound and the emotional preparation of the patient. In more advanced stages of the disease, it is best to delay reconstruction for a recovery period following adjuvant chemotherapy and irradiation. A frank discussion before reconstruction of each patient's prognosis is always necessary and is especially important in those patients

Drs. Hartrampf, Black, and Beegle practice plastic surgery. Send reprint requests to Dr. Hartrampf, 993-C Johnson Ferry Rd., Atlanta, GA 30342.

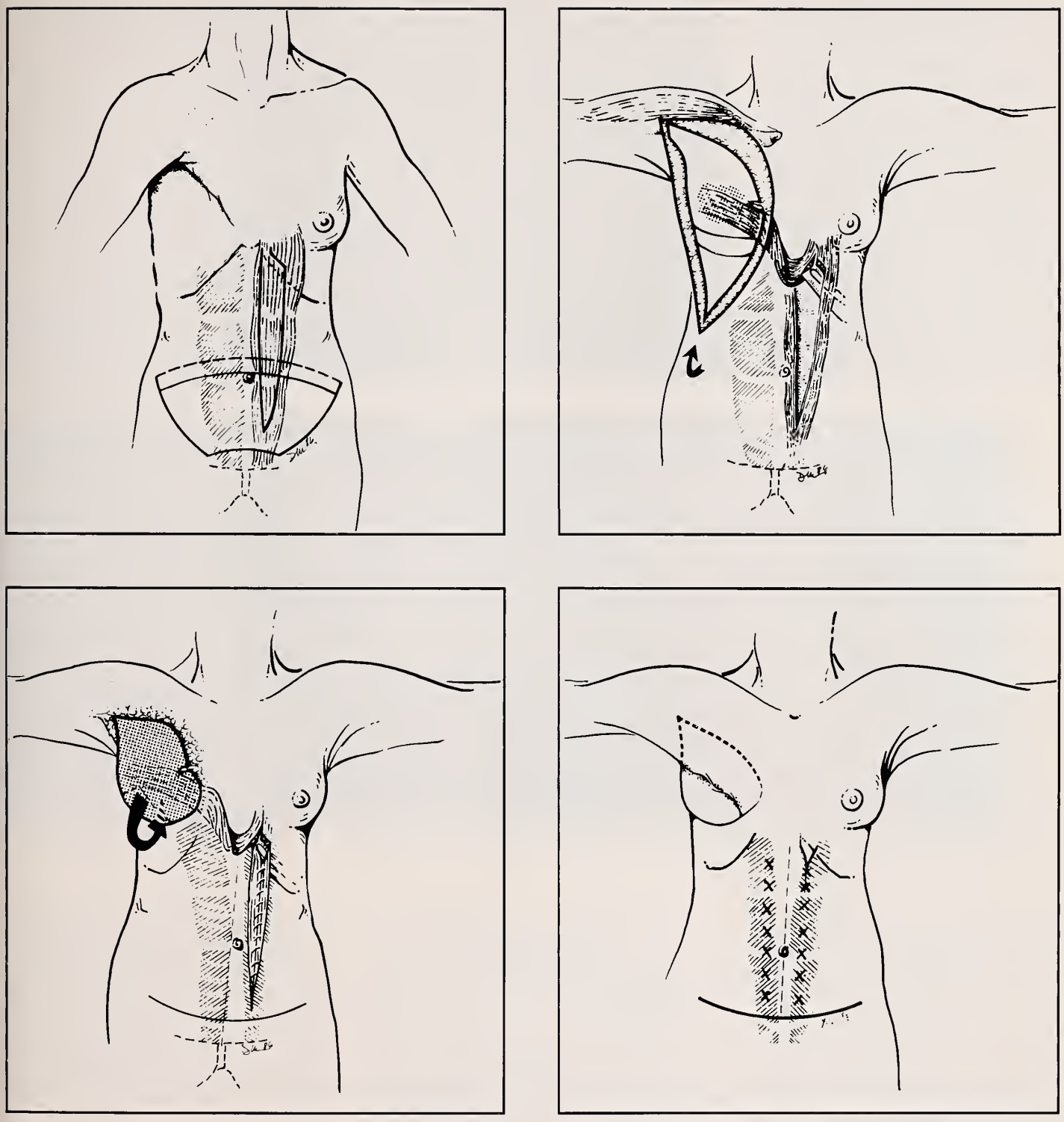

*Figure 1 — The transverse abdominal island flap operation. Artist concept of operative procedure in a unilateral reconstruction.*

*a. Design of lower abdominal ellipse with contralateral rectus muscle pedicle.*

*b. Transverse abdominal flap elevated and rotated 90°, then passed through a subcutaneous tunnel into the mastectomy defect. Central portion of rectus muscle is detached from ribs and isolated on deep superior epigastric vessels and small segment of muscle.*

*c. The abdominal wall defect is closed in two layers. The two remaining segments of rectus muscle are closed from rib margin to lower limits of dissection. The abdominal flap has been formed into the shape of a breast.*

*d. The anterior rectus sheath is closed with two rows of #1 nylon and the right side of the abdominal fascia has been plicated with #1 nylon to centralize the umbilicus and balance the abdominal wall. The abdominal skin has been closed horizontally in the lower abdomen.*

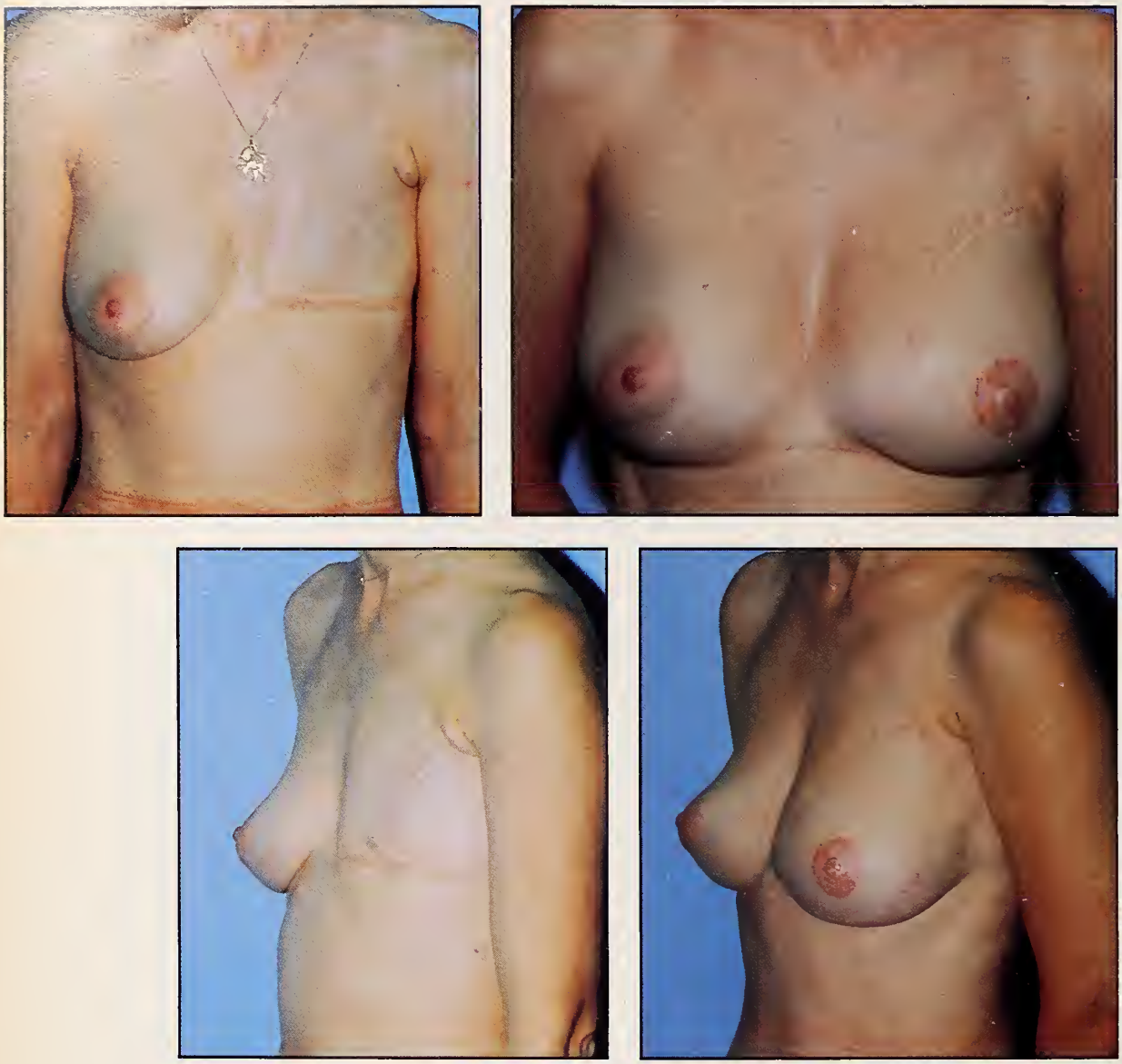

*Figure 2 —*
*a. Thirty-eight year-old woman with a modified radical mastectomy.*
*b. Two years after reconstruction using the transverse abdominal island flap method. The breast mound was formed in a single operaiton. No alloplastic material was used in either breast.*
*c. Preoperative lateral view.*
*d. Postoperative lateral view. The abdominal scar is low and the abdominal wall is strong.*

with Stage II and III disease who may face recurrence after reconstruction. It is incumbent upon the plastic surgeon to accomplish the breast reconstruction as expeditiously as possible, hopefully in no more than two or three operative procedures, and with minimal morbidity, so that the patient may continue her life with a new breast that is trouble free and not be burdened with the old problems formerly associated with some breast reconstructions.

There is currently some enthusiasm for immediate breast reconstruction.[2] Several studies have shown that patients who have immediate breast reconstruction experience less anxiety and depression related to their mastectomy.[3]

## Major Categories of Breast Reconstruction

### *I. Reconstruction with Autogenous Tissue*

The transverse abdominal island flap is now established as a realistic means of transferring a large quantity of tissue from the lower abdomen to the anterior chest wall for breast reconstruction.[4, 5, 6] Skin and fat are taken from the lower abdomen in a transverse dimension, and the donor site is closed primarily with a resulting low transverse abdominal scar (Figure 1). Because this large flap is transferred in one stage on a long narrow vascular pedicle, it affords flexibility in positioning the tissue on the chest wall. This allows the transferred tissue to be shaped and tailored into a natural appearing breast mound. The long thin vascular pedicle also permits tunneling the tissue through the epigastrium into the breast pocket, thereby eliminating unsightly "dog ears" or pedicle fullness around the reconstructed breast.

*Unique Benefits of Reconstruction with Autogenous Tissue*

1. A silicone implant is usually not required, therefore the breast remains naturally soft over the patient's lifetime.
2. In over half of the patients, the shape and size of the new breast can be adjusted to produce a natural ptosis that matches the opposite breast.

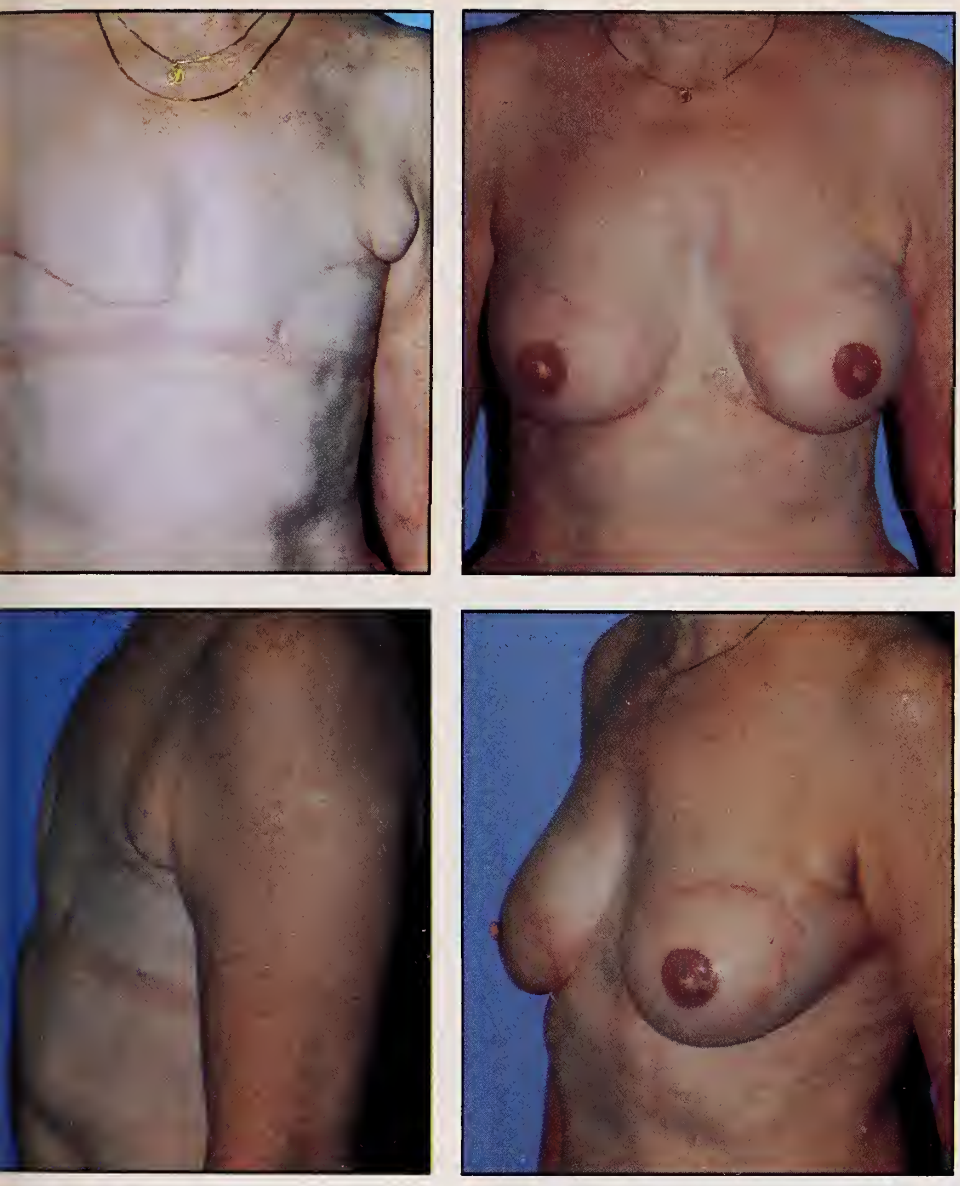

*Figure 3 —*
*a. Fifty-seven year-old woman with bilateral modified radical mastectomies.*
*b. Patient 10 months following bilateral reconstruction with autogenous tissue using the transverse abdominal island flap method.*
*c. Preoperative lateral view.*
*d. Postoperative lateral view.*

3. This method of reconstruction is successful in a number of problem cases that are difficult to manage by other techniques, such as the radical mastectomy, the irradiated chest, and correcting previous unsatisfactory reconstructions.

### *Indications for Transverse Abdominal Island Flap Reconstruction*

*a) Salvage procedures of the breast and chest wall*

Extensive bony and soft-tissue defects of the chest wall resulting from radical procedures for breast cancer can be reconstructed with the transverse abdominal island flap, often with spectacular results. Frequently these extensive chest wall problems are accompanied by heavy irradiation damage and even frank skin ulceration in some patients. These patients have no other reconstructive options available to them, either because the latissimus dorsi muscle is denervated or because other procedures have failed to correct the problem. The transverse abdominal island flap can provide the necessary coverage for even the most extensive defects and will introduce revascularization to the area.

*b) Reconstruction of the radical mastectomy*

No other procedure can reconstruct the radical mastectomy defect as completely as the transverse abdominal island flap. This method will reproduce the missing anterior axillary fold (the pectoralis major muscle), fill the infraclavicular hollow, and at the same time produce a nice breast that in most cases will match the opposite side. As a rule of thumb, it takes one half of the lower abdominal flap to reconstruct the infraclavicular and axillary defect and one half to reconstruct the breast. It is very important that both halves be well vascularized. Therefore, if there is lower abdominal scarring or if for any reason the vasculature to the distant reaches of this flap is impaired, the overall blood supply should be enhanced either by taking two vascular pedicles for the one flap (based on both rectus muscles) or by taking the flap higher on the abdomen, where the blood supply to the flap is more reliable.

*c) Reconstruction of the modified radical mastectomy*

There are a number of acceptable options open to the individual who has had a modified radical mastectomy. These include tissue expansion with implants, implants alone, the latissimus dorsi flap, and the transverse abdominal island flap. Of these, the transverse abdominal island flap produces the most remarkable results. The new breast will very often match the opposite side and will have a natural shape with permanent softness (Figure 2).

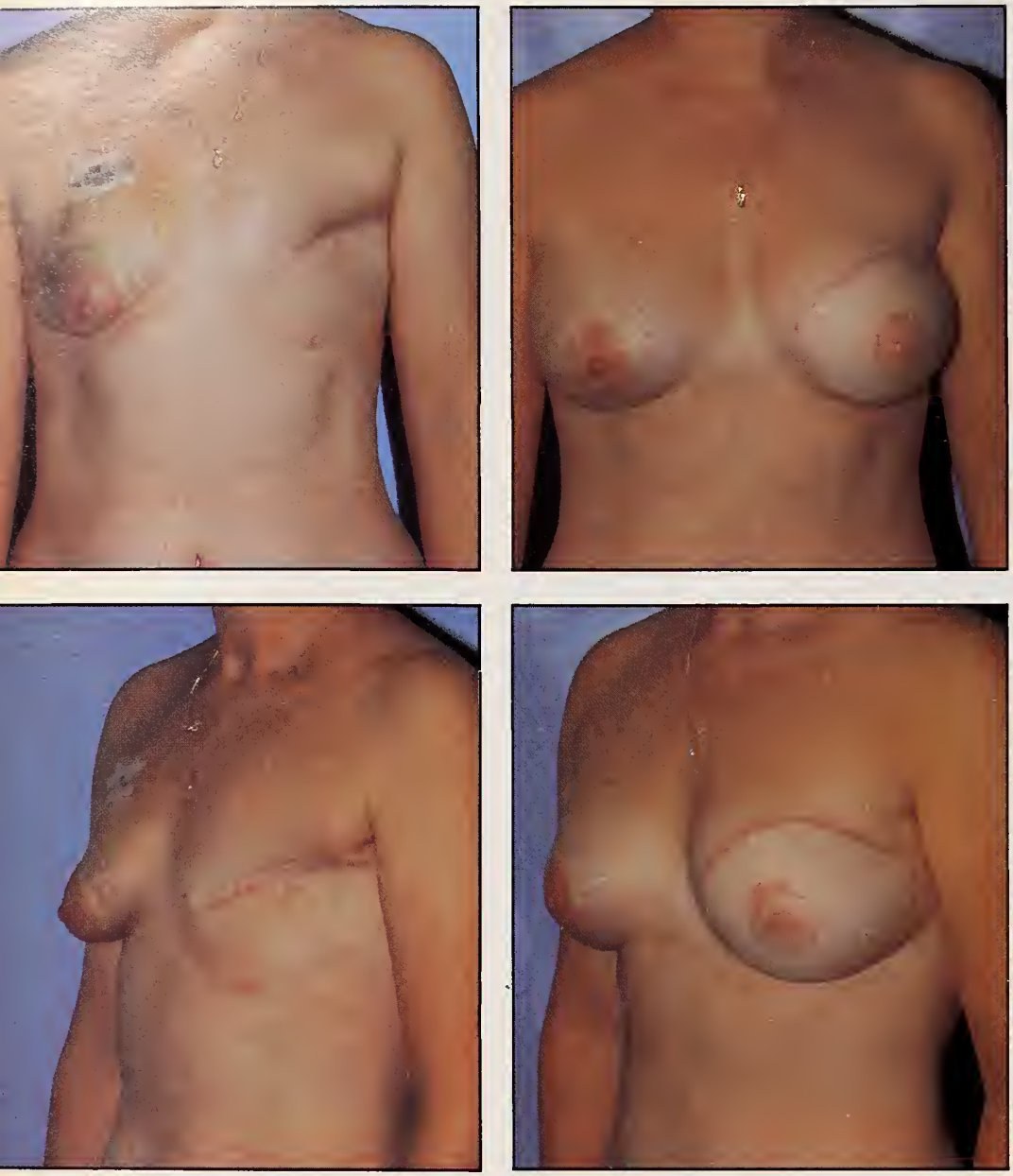

*Figure 4 —*
*a. Forty-two year-old woman with left modified radical mastectomy and right breast at extreme risk and multiple biopsies.*
*b. Two years following right subcutaneous mastectomy and bilateral reconstruction with autogenous tissue using the transverse abdominal island flap method.*
*c. Preoperative lateral view.*
*d. Postoperative lateral view.*

*d) Reconstruction of the bilateral mastectomy*

This flap is especially suited to the bilateral breast reconstruction (Figures 3, 4). Both superior epigastric vascular pedicles are elevated, and each pedicle carries one half of the lower abdominal flap. This is a dramatic procedure but in fact is extremely safe. Each flap is passed through the common epigastric tunnel and used to fashion a breast on the ipsilateral side.

*e) The subcutaneous mastectomy patient with silicone intolerance*

A distressingly large number of patients have significant complications following subcutaneous mastectomy with silicone implant reconstruction. Most of these individuals have had multiple attempts to correct the problem with the same disappointing result. These women can be rehabilitated by removing the silicone implants and placing well-vascularized autogenous tissue flaps from the lower abdomen into the subcutaneous pocket.

*The Disadvantages of the Transverse Abdominal Island Flap Procedure:*

1. The reconstructive surgeon may have limited experience with this relatively new procedure.
2. The complication rate may be higher than with other myocutaneous flaps, such as the latissimus flap, even when the operation is properly performed; if improperly performed, the chance of a major complication is significant.
3. The operation is longer than other reconstructive procedures and demands the surgeon's constant attention. A major commitment is required of the surgeon if the operation is to be consistently successful.
4. The patient's abdominal recovery time may be lengthy. The operation should never be presented to the patient as an abdominoplasty.

*Patient Selection*

Poor patient selection is the leading cause of problems with this operation. Conditions that adversely affect the operation and increase the risk of complications are:

1. The presence of systemic disease such as diabetes, hypertension, etc.
2. Chronic and heavy smoking
3. Obesity
4. Malnutrition or extreme thinness

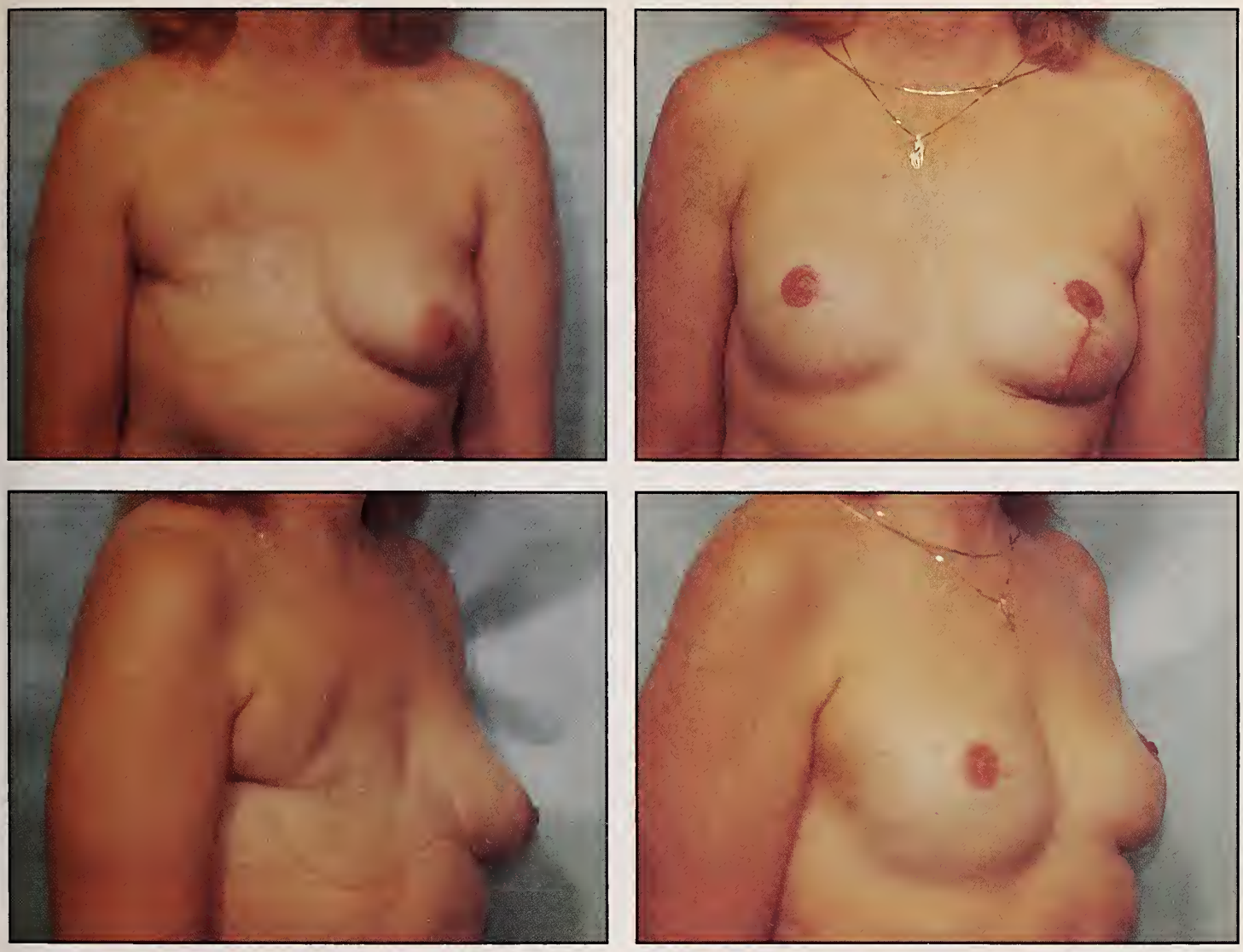

*Figure 5 —*
*a. Thirty-three year-old woman with right modified radical.*
*b. Following reconstruction with submuscular silicone implant. A mastopexy was required on the left side to establish symmetry.*
*c. Preoperative lateral view.*
*d. Postoperative lateral view.*

5. Abdominal scars that divide the critical vascular pedicle, damage the major periumbilical perforators, or cross the flap so that adequate tissue harvest is not possible

*Free Transfer of Autogenous Tissue by Microvascular Surgery*

When abdominal scarring or other considerations prevent the use of a transverse abdominal island flap reconstruction, a free transfer of fat and skin from another part of the body can be employed. The tissue is transferred from either the infraumbilical area or from the buttocks. In the transfer of free tissue, the blood supply of the tissue being transferred is anastomosed to recipient vessels on the chest wall using the microscope for small vessel hookup. Although this is a reliable method of reconstructing mastectomy defects and other large chest wall defects, microsurgical tissue transfer is usually reserved for cases that cannot be reconstructed by one of the more conventional means.

### *II. Reconstruction With a Silicone Prosthesis*

An effective breast mound can be formed using a silicone implant (Figure 5). In general, implants may be used after most subcutaneous, simple, and modified radical mastectomies, when the soft tissue on the chest wall is supple and adequate. Contraindications to reconstruction using an implant are radical mastectomy, extremely tight chest wall skin, and an irradiated chest wall. In these cases, a prosthesis will give an inadequate restoration, an unnatural appearance, and there is a good possibility that the implant will erode the skin pocket and become exposed.

Reconstruction using implants

provides a relatively simple means of breast reconstruction. The surgery can often be performed on an outpatient basis, and the morbidity and recovery time associated with this type of reconstruction is minimal. Reconstruction with an implant is best suited to women who do not have the motivation or time for reconstruction with autogenous tissue. It is also a good choice for women who have medical problems that prohibit reconstruction with autogenous tissue. Unfortunately, there are significant problems associated with this form of reconstruction. The body will often form dense scar tissue around the prosthetic implant resulting in a firm, misshapen and painful breast. In addition, the implant can only provide a rounded breast mound, and therefore it is often difficult to achieve symmetry with the opposite breast without altering the normal breast. A new type of implant with a polyurethane covering has been reported to reduce the chance of scar tissue contracture associated with the standard silicone implant. Studies are being conducted at this time to evaluate this new implant.

### *III. Tissue Expanders in Breast Reconstruction*

The tissue expander is an inflatable silicone implant that can be placed in the breast pocket either at the time of mastectomy or at a later date and gradually inflated over four to six weeks time by percutaneous injection of saline. The overlying skin envelope is thus stretched over time. The chest skin is expanded to a greater volume than the desired final result, in order to provide the final breast mound with a degree of ptosis. Once skin expansion is completed, the tissue expander is removed, and a permanent implant is inserted. Tissue expansion is a safe and effective method of breast reconstruction for patients who have tight but healthy soft tissue in the chest wall; however, tissue expanders have the disadvantages associated with all silicone implants.[7]

### *IV. Reconstruction Using the Latissimus Dorsi Musculocutaneous Flap*

The latissimus dorsi muscle with an overlying skin island can be utilized to carry additional soft tissue to the chest wall in breast reconstruction.[8] An implant is placed under the flap to establish a breast mound. With the advent of tissue expanders and autogenous tissue transfers, this method of breast reconstruction is used less frequently. It still serves a useful role when augmentation of the soft tissue of the chest wall is needed, either after implant surgery or after reconstruction with autogenous tissue.

## SUMMARY

Breast reconstruction today is a realistic and vital part of total breast cancer treatment. All physicians should be well informed on current methods of reconstruction so that they can present the facts to their patients in an encouraging yet realistic manner.

Plastic surgeons are charged with the task of becoming proficient in breast reconstruction procedures in order to offer the mastectomy patient a safe, realistic, facsimile breast that will be trouble free.

Fortunately, there are several good operations for restoring the breast after mastectomy. The method of reconstruction should be chosen by matching the desires of an informed patient with the indications and contraindications in each case.

In general, silicone reconstruction is expedient and satisfactory in most patients. However, it cannot compete with autogenous tissue transfer for filling severe chest wall defects, covering irradiated areas, creating a large ptotic breast, or providing a natural appearing, soft breast mound.

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# REHABILITATION AFTER MASTECTOMY

*John Bostwick, M.D.*

***Reach to Recovery and breast reconstruction options are discussed.***

TERESE LASSER HAD a radical mastectomy in 1952 for breast cancer. She faced the usual problems of recuperation — physical rehabilitation, physical appearance, dress — alone. But the biggest problems were psychologic — how to become a "whole woman" again, how to cope with the fear of breast cancer, the feelings of loss of femininity and body image. She realized the psychologic impact of a mastectomy was unparalleled by almost any other operation and the adjustment to family, marriage, and community, as well as restoration of appearance, and arm motion were not easy without help and reassurance.[1]

### Reach to Recovery

The Reach to Recovery Program grew out of the realization that it is valuable for the rehabilitation of the breast cancer patient to see and talk to a woman who had been in a similar situation, learned to cope, and had resumed her everyday activities. Reach to Recovery became an integral part of the American Cancer Society in 1969. Reach to Recovery works through qualified, selected, and trained volunteers who have adjusted to their breast cancer treatment. They visit the breast cancer patient after the physician has authorized the visit, and an appointment is made. The volunteer brings a kit containing a temporary breast form, manuals of information, and appropriate literature for husands and other loved ones. She can also give advice on obtaining a permanent prosthesis; however, no products are endorsed. The Reach to Recovery Program in Georgia made over 1800 initial visits to breast cancer patients in 1986.

### Expansion of Services

Cancer management is becoming increasingly individualized with respect to both diagnostic procedures and treatment. The Reach to Recovery Program in Georgia has expanded in the last few years to meet the specialized needs of the specific breast cancer patient. Because of the many new approaches to the management of breast cancer, some American Cancer Society Units have visiting volunteers available who have had radiation therapy, chemotherapy, as well as conservative surgery and radiation therapy. Carefully selected volunteers may even be available to meet the woman before surgery. Reach to Recovery can also provide information to women interested in breast reconstruction. Volunteers who have had reconstruction are available to visit women who are deciding about this aspect of rehabilitation. Reach to Recovery is successful when the woman who has had breast cancer is able to return to her normal activities, is proud of herself, is informed about her disease and its treatment, and resumes her very special place with her family and friends.[2]

### Breast Cancer Support Group — Bosom Buddies

The Reach to Recovery volunteer makes one visit, and possibly another follow-up visit; however, many breast cancer patients find that they get additional support from a sharing group of women who have had breast cancer surgery. These women share common experiences and problems, as well as common ideas and solutions at their monthly meetings. The "Bosom Buddies" breast cancer support group was started by Mrs. Vicki Castleberry and has grown throughout the Metropolitan area and State, and is now incorporated into the Services and Rehabilitation Program of the American Cancer Society, Georgia Division.

### Breast Reconstruction

Breast cancer characteristically affects healthy women in the prime

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*Reach to Recovery volunteers give sympathetic support.*

of life. Tragically, this serious and deadly disease poses a dual threat to women: attacking their lives and their femininity at the same time. Breast reconstruction is now a major addition to the comprehensive management and rehabilitation of the woman with breast cancer. Before its development, the external breast prostheses that women placed in their brassieres were the only possibilities that they had to disguise their deformities. Psychologic studies revealed, however, that women never incorporated these external forms into their body image as representing a restored breast. They felt that they were simply hiding the deformity from themselves and others.[3] Insurance companies have now recognized the need for breast reconstruction after mastectomy, and breast reconstruction is usually covered under most policies and by HMOs.

In an effort to adjust to the trauma of breast cancer and breast loss, women have encouraged reconstructive surgeons to develop techniques to restore realistic and nat-

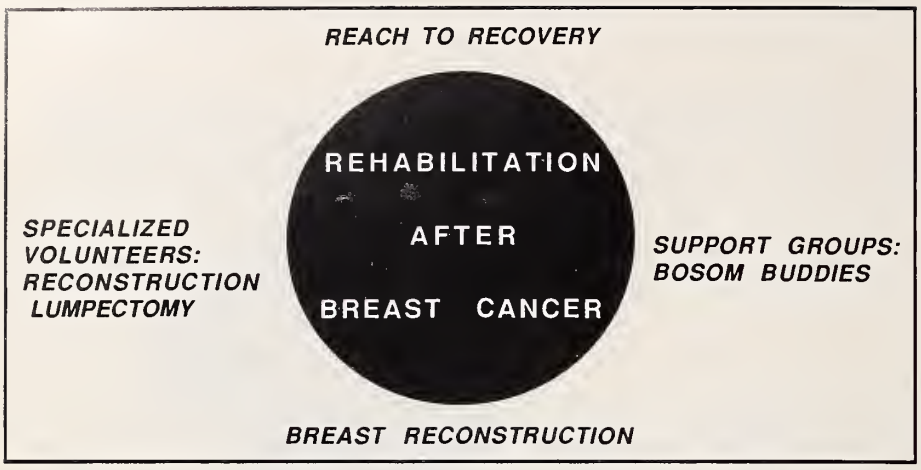


*Figure 1 — Rehabilitation after breast cancer is supported by the Services and Rehabilitation Division of the American Cancer Society. Breast reconstruction is now an important component of rehabilitation after breast cancer.*

ural breast shape after mastectomy. In the past 10 years alone, breast reconstruction has advanced from an unusual and rare request, which frequently produced unsatisfactory and incomplete results, to an integral part of the management of the woman who has had a mastectomy for breast cancer.[4] This growing acceptance has been founded on the development of new techniques which produce more natural and aesthetically acceptable breasts and on increased information about the risks associated with this surgery. It is now generally accepted that breast reconstruction does not hide potential local recurrences, but instead produces positive psychologic benefits for women, often giving them a renewed sense of "wholeness and return to normalcy."

**Timing of Breast Reconstruction**

A woman's breast can be reconstructed at the time of the mastectomy or after a delay of months or years. Three months to 1 year following the mastectomy is the usual waiting period. This interval allows the patient to recover from the mastectomy, to have any indicated adjuvant radiation therapy, chemotherapy, or hormonal therapy. She also has time to select a reconstructive surgeon as well as the appropriate individualized technique for breast reconstruction. And she has time to investigate the various options for breat reconstruction and management of the opposite breast. In recent years, immediate breast reconstruction performed at the time of the modified radical mastectomy has gained wider acceptance.[5] This one stage operation is very appealing to the patients who do not want to experience breast loss. Immediate breast reconstruction can be done with safety and without compromise of the cancer treatment. Even if the reconstruction is done at the time of the mastectomy, additional operations may be necessary to achieve the most satisfactory and aesthetic results. The nipple-areola is usually reconstructed as a separate procedure after the reconstructed breasts are stable and symmetrical.

*The Reach to Recovery Program grew out of the realization that it is valuable for the rehabilitation of the breast cancer patient to see and talk to a woman who had been in a similar situation, learned to cope, and had resumed her everyday activities.*

**Methods of Breast Reconstruction**

***Breast Implant Under the Available Tissues***

The most common type of operation for breast reconstruction is also the simplest. A silicone breast implant is positioned through the mastectomy incision and placed beneath the muscles and fascia behind the area on the mastectomy.[6] This procedure is appropriate for reconstructing the breasts of women whose opposite breast is small to moderate size with minimal ptosis (Figure 1).

***Breast Tissue Expansion and Permanent Implant***

Tissue expansion allows reconstruction of larger and more natural appearing ptotic breasts than can be achieved with simple silicone breast implant insertion. It also permits breast reconstruction without the need of flaps from other areas of the body and therefore simplifies the reconstruction.[7] Initially, the tissue expander, a silicone breast implant envelope with a separate fill valve, is positioned through the mastectomy scar beneath the musculofascial layer of the chest wall. These tissues are expanded by serial injections of the saline solution in the reconstructive surgeon's office. During a second operation, the tissue expander is exchanged for a permanent, properly sized silicone breast implant which will provide an attractive and symmetrical breast reconstruction. A fibrous capsule can develop about silicone breast implants, constricting the implant and causing it to feel firm, with possible displacement of the implant or distortion or assymetry of the breast reconstruction. This problem is much less common when the silicone breast implant is placed beneath the musculofascial layer, rather than under the skin of the mastectomy (Figure 2).

***Latissimus Dorsi Musculocutaneous Flap***

When the tissues remaining after the mastectomy are relatively tight

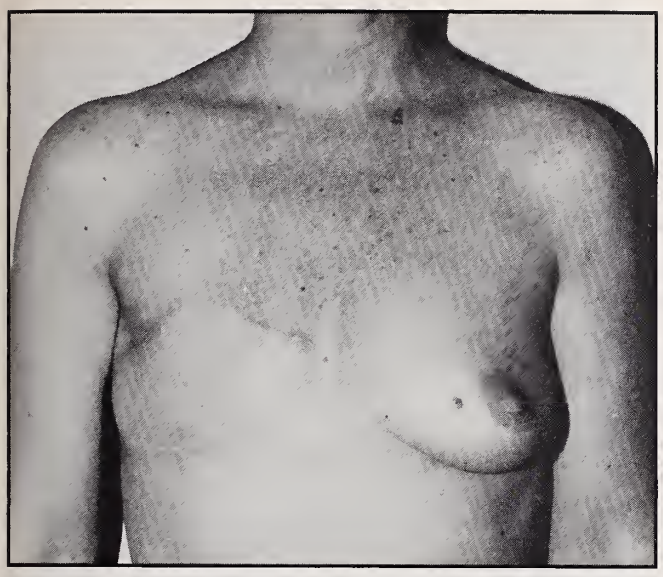

*Figure 2A — This woman had a modified radical mastectomy for Stage I breast cancer. She requested breast reconstruction to match her opposite breast after augmentation mammaplasty with a silicone breast implant.*

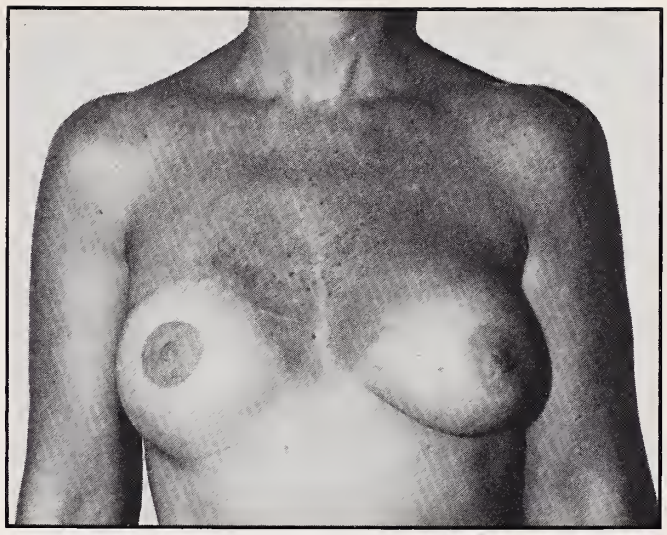

*Figure 2B — One year after breast reconstruction with a silicone breast implant placed under the available tissues to give symmetry with the opposite breast which had an augmentation mammaplasty. The nipple-areola reconstruction was done as a second operation.*

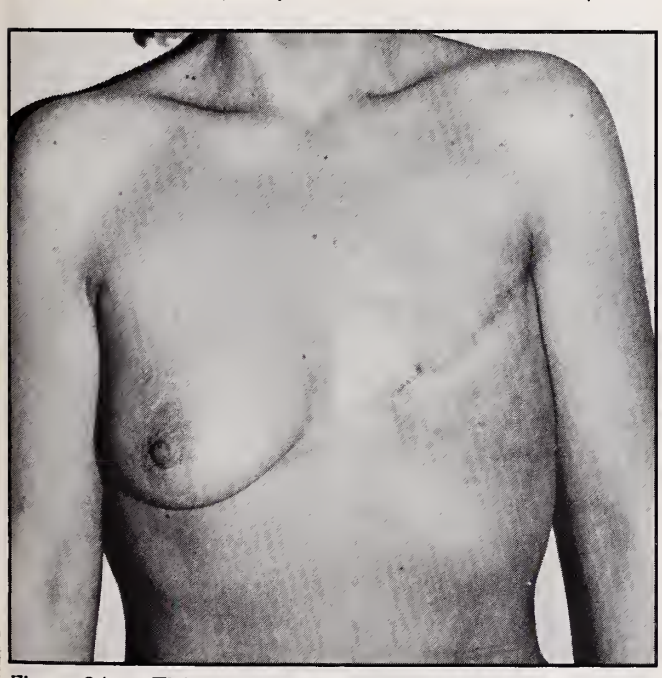

*Figure 3A — This woman requested breast reconstruction after a modified radical mastectomy for breast cancer.*

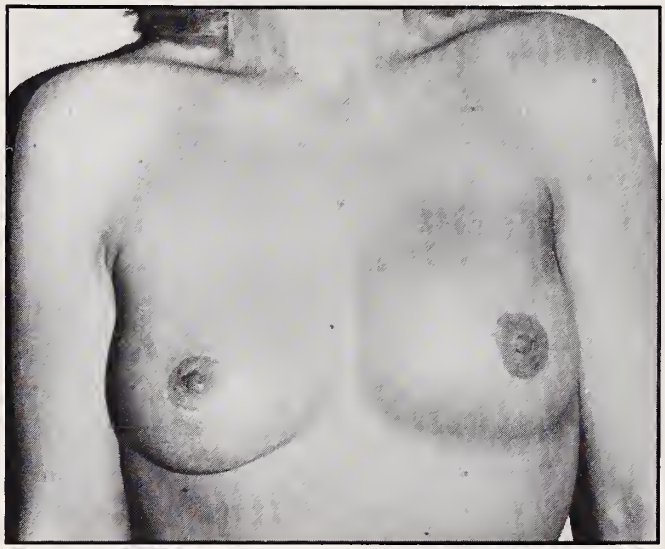

*Figure 3B — The tissues were tight, and modified tissue expansion was used to stretch the tissues to accommodate the silicone breast implant. A mastopexy was done for the opposite breast. A nipple-areola reconstruction was done at the time of the second stage breast reconstruction.*

and tissue expansion will not provide a satisfactory breast reconstruction, a flap of distant tissue is necessary. The latissimus dorsi musculocutaneous flap is a flap of skin, fat, and muscle from the back. The flap is planned on the back to include the proper amounts of skin and muscle to replace the missing tissue and permit the introduction of a silicone breast implant. The latissimus dorsi muscle is used to replace the removed pectoralis major muscle and the outer layer of skin is removed from the skin flap and used for axillary fill.[8] The latissimus dorsi musculocutaneous flap is very relaible; however, tissue loss with this flap has been about 2%. Breast reconstruction with this method also requires the use of a silicone breast implant, and firmness and distortion around the implant is possible (Figure 3).

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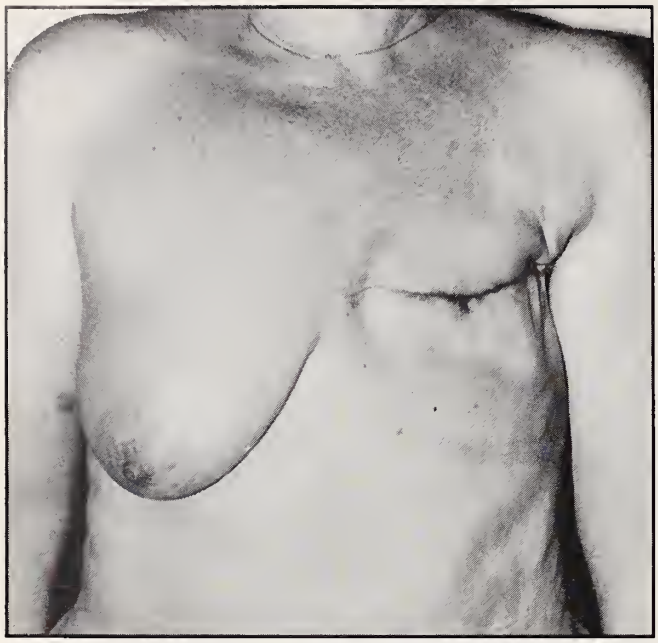

*Figure 4A — This woman requested breast reconstruction after a modified radical mastectomy for Stage I breast cancer. She had undergone an abdominoplasty several years before her mastectomy, and the T.R.A.M. flap could not be used.*

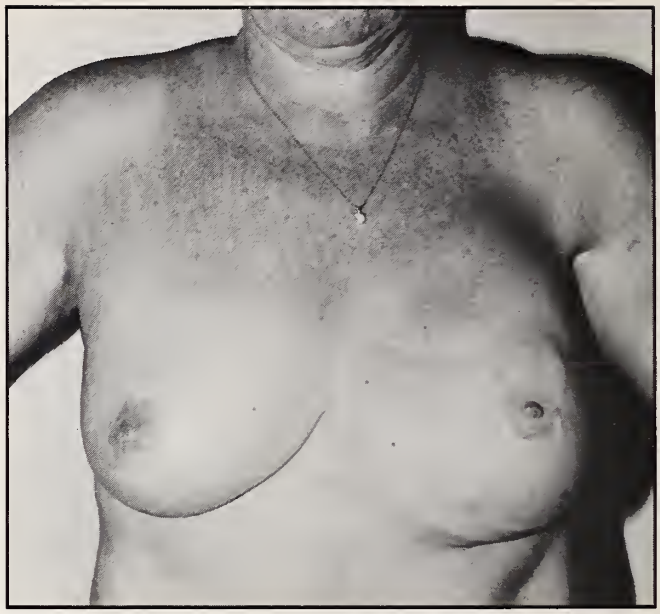

*Figure 4B — Breast reconstruction was done with a latissimus dorsi musculocutaneous flap, with a silicone breast implant placed beneath the flap and the remaining tissue of the chest wall. A reduction mammaplasty was done for the opposite breast. The nipple-areola reconstruction was done at the time of a second operation.*

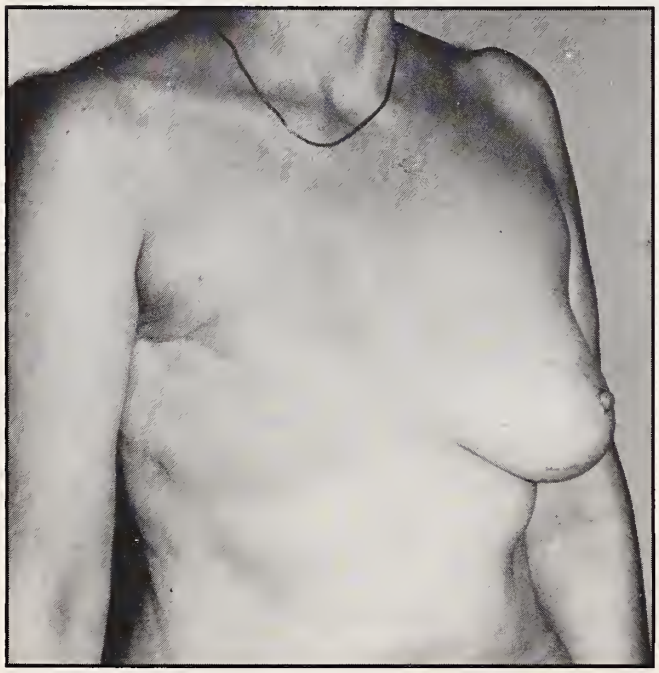

*Figure 5A — This woman had radiation therapy after a modified radical mastectomy for Stage II breast cancer. She requested breast reconstruction to match her opposite breast and wanted her abdomen reduced.*

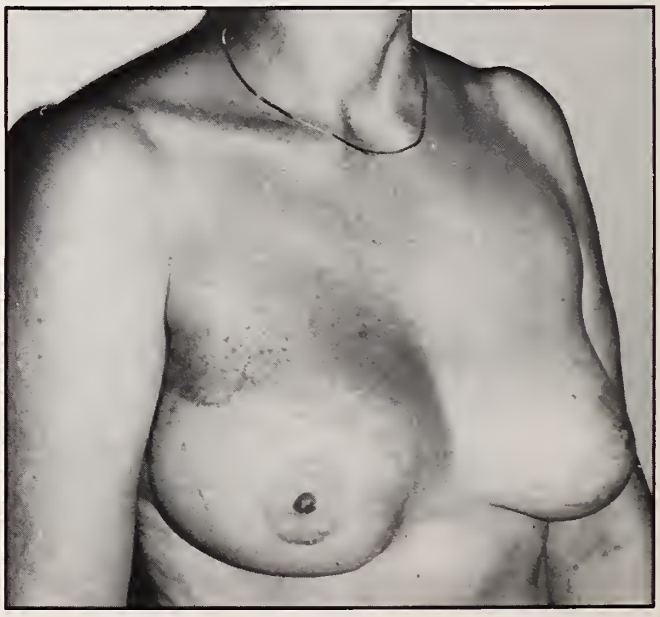

*Figure 5B — A breast reconstruction with the transverse rectus abdominis musculocutaneous flap brought enough tissue to the chest wall for a breast reconstruction without a silicone breast implant. The abdomen was reduced and tightened with the closure of the transverse rectus abdominis musculocutaneous flap donor site.*

include the proper amounts of skin and muscle to replace the missing tissue and permit the introduction of a silicone breast implant. The latissimus dorsi muscle is used to replace the removed pectoralis major muscle and the outer layer of skin is removed from the skin flap and used for axillary fill.[8] The latissimus dorsi musculocutaneous flap is very relaible; however, tissue loss with this flap has been about 2%. Breast reconstruction with this method also requires the use of a silicone breast implant, and firm-

ness and distortion around the implant is possible (Figure 3).

### *Transverse Rectus Abdominis Musculocutaneous (TRAM) Flap*

When a woman requests a breast reconstruction and she needs a flap of additional tissue for a satisfactory reconstruction, it is possible to move an ellipse of lower abdominal fat and skin to the breast area to be fashioned into the shape of the new breast.[9] This transverse rectus abdominis musculocutaneous (TRAM) flap depends on the blood supply going into the lower abdominal fat from the underlying rectus abdominis muscle. This operation is complex and requires a reconstructive surgeon well versed in the technique and a properly selected patient who understands the magnitude of the operation as well as the time needed for the 2 to 3 month recovery period.

This musculocutaneous flap depends on good flow through the tiny blood vessels of the tissue. When the microcirculation is compromised, such as with cigarette smoking or in a woman with diabetes mellitus, there may be insufficient blood flow to the flap, and it may not survive. A careful and secure abdominal closure is necessary to give a tight abdominal wall and avoid the occurrence of a post-operative hernia (Figure 4).

*In recent years, immediate breast reconstruction performed at the time of the modified radical mastectomy has gained wider acceptance.*

### *Gluteus Maximus Musculocutaneous Flap and Microsurgical Transfer*

In the unusual situation when a woman requests breast reconstruction and the other flap techniques are not suitable, her breast can be reconstructed with fat and skin from the buttocks. The tissue, along with a segment of the gluteus maximus muscle, is elevated on its vascular pedicle. The internal mammary vessels of the breast area are connected to the vessels of the flap with microvascular technique.[10]

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# Read this like your life depends on it.

Breast cancer found early and treated promptly has an excellent chance for cure. About a week after your period, practice this self-examination.

## 1. In bath or shower.

Fingers flat, move opposite hand gently over each breast. Check for lumps, hard knots, thickening.

## 2. In front of a mirror.

Observe breasts. Arms at sides. Raise arms high overhead. Any change in nipples, contours, swelling, dimpling of skin? Palms on hips: press down firmly to flex chest muscles.

## 3. Lying down.

Pillow under right shoulder, right hand behind head. Left hand fingers flat, press gently in small circular motions starting at 12 o'clock. Make about three circles moving closer to and including nipple. Repeat on left.

AMERICAN CANCER SOCIETY®

# The Medical Management of Breast Cancer

*R. Martin York, M.D.*

IT IS CONVENIENT to divide the medical management of breast cancer into three topics: adjuvant treatment, treatment of metastatic disease, and treatment of complications.

### Adjuvant Treatment

The adjuvant treatment of breast cancer has received a great deal of attention in recent years. Adjuvant treatment simply means the giving of systemic treatment to a patient without any evidence of metastatic disease but who is at reasonable risk of relapse in order to lower the chances of relapse. The theoretical basis for this approach is the concept that cancer present in very small quantities (micrometastases) is easier to eradicate with systemic treatment than cancer in larger quantities.

The need for adjuvant treatment after primary treatment is based on the status of the axillary lymph nodes. If any of the nodes are involved, the chances of relapse increase dramatically. Recently, other prognostic factors such as age, size of the primary tumor, estrogen and progesterone receptor status, histologic grade, and labeling index have all been shown to be important. Younger age, a large primary tumor, estrogen and progesterone receptor negative, poorly differentiated lesions, and tumors with a high labeling index have all been shown in various studies to indicate an increased chance for relapse.

There have been a large number of clinical studies done in patients after primary treatment to determine the most appropriate adjuvant treatment for the various patient groups. Originally, the use of chemotherapy with cytoxan, methotrexate, and 5-fluorouracil (CMF) given for one year was the standard approach. Early data indicated an increased survival for pre- and post-menopausal patients treated with 1 year of CMF. Later, however, it became clear that survival was not increased in post-menopausal patients. Further research indicated that 6 months of the CMF regimen was equivalent to 12 months. With the advent of widespread availability of estrogen and progesterone receptors, adjuvant studies using hormones were done.

The data from the various studies were confusing and often conflicting, so that a consensus conference was held at the National Cancer Institute in 1985 to try to resolve the issues. The recommendations from that conference can be accepted as the standard of practice for physicians in a non research practice situation. For a pre-menopausal patient with positive axillary lymph nodes, 6 months of chemotherapy with cytoxan, methotrexate, and 5 Fu is recommended. Hormone therapy for pre-menopausal women — irrespective of receptor status — is not recommended. For post-menopausal patients with positive axillary nodes, chemotherapy has not been shown to increase survival and is not recommended. For patients with positive receptors, 2 years of Tamoxifen is the current treatment of choice. For post-menopausal patients with negative receptors, no treatment has been shown to increase survival.

*There have been a large number of clinical studies done in patients after primary treatment to determine the most appropriate adjuvant treatment for the various patient groups.*

Although not specifically addressed at the conference, recent research has shown an increased disease-free survival in premenopausal women with negative receptors given 6 months of CMF. These results have not yet been confirmed in other studies, and the data are early, but many oncologists offer 6 months of chemotherapy to young women with negative receptors.

### Treatment of Metastatic Disease

The management of a patient with metastatic breast cancer can be challenging. Breast cancer can me-

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tastasize to a wide variety of sites — lungs, bone, liver, pleura, nodes, brain, meninges, marrow, subcutaneous tissue — causing a number of different signs and symptoms that are usually not specific for breast cancer. Breast cancer is also notorious for recurring late, sometimes many years after primary treatment. The most appropriate way to follow a patient after primary treatment and adjuvant therapy is controversial. Some oncologists prefer to perform "surveillance" studies such as bone scans, CAT scans, chest x-rays, etc. at regular intervals, even if the patient is asymptomatic. Others prefer to wait for signs or symptoms to appear and order appropriate studies. Whether early aggressive diagnostic techniques that allow for earlier treatment extend survival is a matter of debate that has not been totally resolved, so that this issue presently is largely up to the physicians' judgment.

*The most appropriate way to follow a patient after primary treatment and adjuvant therapy is controversial.*

Once the diagnosis of metastatic breast cancer is made, the choice of systemic treatment depends largely on the estrogen and/or progesterone receptor status of the primary tumor or metastatic site and the site of the metastases. Patients whose tumors are receptor poor have a less than 10% chance of responding to hormone therapy and should be treated with chemotherapy. Patients whose tumors are receptor positive are treated with hormones, with the exception of patients with liver metastases or lymphangitic spread in the lungs. These patients should be treated with chemotherapy.

*Hormone Therapy*

Breast cancer is one of three cancers that respond to hormone therapy; prostate and endometrium are the other two. Breast cancer responds to a wide variety of different hormones and hormone-ablative maneuvers. The hormone treatment of breast cancer is based largely on empirical observations. The exact scientific rationale and mechanisms involved have not been elucidated.

Until the discovery of the antiestrogen compounds in the early 1970s, the principle of hormone treatment of breast cancer was to *remove* estrogen production in premenopausal patients by removal,or irradiation, of the ovaries, and to *add* estrogens, usually in the form of the synthetic estrogen diethylstilbesterol (DES), in post-menopausal patients. The antiestrogen tamoxifen was shown in the mid 1970s, however, to have almost identical anti-cancer activity as DES in post-menopausal women and with much less side effects, so it became the hormone treatment of choice for post-menopausal patients with metastatic breast cancer. More recently, a number of studies have compared tamoxifen with oophorectomy in pre-menopausal patients, and it has been shown to have equivalent activity, so that tamoxifen is also now the preferred initial treatment for premenopausal patients.

As mentioned earlier, there are a number of other hormones and hormone ablations that are effective in the treatment of metastatic breast cancer. If the patient responds to treatment with tamoxifen and then relapses, these other hormones and/or ablations can be used in serial fashion as long as the patient continues to respond with each new treatment used at the time of relapse. Some patients can be "carried" in this fashion on serial treatment with hormones for several years. Once the patient fails to respond to one of the hormone maneuvers, the chances of responding to different hormone maneuvers is low, and most oncologists would start treatment with chemotherapy. A complete discussion of each of these hormone maneuvers is beyond the scope of this article but will be briefly discussed. There is no exact schedule of serial hormone treatments that has been shown to be the best, and each oncologist tends to have their own favorite scheme.

Various progesterone preparations have been shown to be quite effective in treating metastatic breast cancer. In fact, several recent studies suggest they are equal in efficacy to tamoxifen. The most popular is medroxyprogesterone acetate at a dose of 40 mg qid. The progesterone preparations are remarkably free of side effects.

Diethylstilbesterol (DES) is very effective. However, as noted earlier, DES has a long list of side effects and toxicities, including nausea, hypercalcemia, thrombophlebitis, and hypertension. DES does have the distinct advantage of being much less expensive than tamoxifen or the progesterone derivatives. DES is containdicated in premenopausal patients, especially those who have had a response to oophorectomy.

Androgens, usually in the form of Halotestin, is active against breast cancer. They are not as active as tamoxifen or progesterone and are therefore used as third or fourth line agents. The virilizing side effects are a distinct disadvantage for these agents.

*Patients whose tumors are receptor positive are treated with hormones, with the exception of patients with liver metastases or lymphangitic spread in the lungs.*

In the past, adrenalectomy was often used to treat metastatic breast cancer. Adrenal hormones are converted to estrogen in adipose tissue, so the adrenalectomy removed this source of estrogens. Surgical adrenalectomy has been replaced by a medical adrenalectomy using aminoglutethimide. Aminoglutethimide blocks steroid synthesis, so

that the patient must take replacement cortisone. Depression is a frequent side effect of aminogluthemide but clears with continued use.

Hypophysectomy can cause objective regressions in some breast cancer patients and in some studies has been particularly effective in giving pain relief. Due to the numerous other options available, this procedure is now infrequently performed.

One new class of agents deserves mention, the leuteotrophic hormone-releasing hormone agonists of which leuprolide is the one currently in use. Leuprolide has been used primarily in prostate cancer, but early studies show activity against breast cancer. Leuprolide's main disadvantage is that it must be given subcutaneously on a daily basis, but studies on newer methods of delivery are in progress.

*Chemotherapy*

Patients with metastatic breast cancer who are receptor negative or who fail to respond to hormones are treated with chemotherapy. There are a number of chemotherapy drugs active against breast cancer. These have been combined in a large number of different combinations that all have reported objective response rates from 40-75%, with the median duration of response 10 months. There is no one regimen that is clearly superior. Some of the common regimens are CMF, 5FU-adriamycin-cytoxan (FAC), and CMF + vincristine and prednisone (the Cooper regimen). Each oncologist has his or her favorite regimen.

*One new class of agents deserves mention, the leuteotrophic hormone-releasing hormone agonists of which leuprolide is the one currently in use.*

The side effects and toxicities of chemotherapy for breast cancer can vary from mild to severe, but are usually mild to moderate and are usually manageable. The most frequent side effects are hair loss and nausea. Some hair loss occurs in almost all patients, but the amount varies a great deal. Some patients lose enough hair to require a wig. The hair loss is always reversible. The severity of the nausea varies also. Some patients note very little nausea, while others have several episodes of vomiting. The nausea and vomiting are usually over by the next day. There are several antinausea drugs available now, so that it is the unusual patient who cannot be helped.

The main toxicity of the drugs is myelosuppression. The nadir of the leukocyte and platelet counts usually occurs at 10-14 days after the therapy. If the granulocyte count is below 500 and the patient has a fever, hospitalization and broad spectrum antibiotics are necessary. If the platelet count gets below 15-20,000, most oncologists would transfuse platelets. Needless to say, these drugs can be very dangerous and should not be used by a physician who is not thoroughly familiar with them.

**Treatment of Complications**

The last topic in the medical management of breast cancer is the treatment of the complications. As mentioned earlier, breast cancer can spread to almost anywhere in the body, causing a wide variety of complications. It is beyond the scope of this article to review these in detail, but the most important ones will be discussed.

Breast cancer spreads frequently to the bone, causing painful boney metastases, often requiring palliative radiation therapy. If the metastasis is in the hip or femur, pathologic fractures can occur, requiring orthopedic management. Metastases to the cervical-thoracic or lumbar spine can be very painful and lead to a spinal cord compression. Many oncologists do a myelogram, or more preferably, an MRI scan of the spine in any patient with spinal metastases to detect early cord impingement and start treatment early to prevent paralysis.

Hypercalcemia is a frequent occurrence in patients with breast cancer metastatic to bone. There are a number of different methods available to treat hypercalcemia: IV saline, mithromycin, calcitonin, steroids, diphosphonates, and gallium nitrate. Breast cancer causes hypercalcemia by direct bone destruction and not by indirect humoral methods.

Pleural effusions due to direct involvement of the pleura are frequent in breast cancer patients. If there is no response to systemic treatment, tube drainage of the pleural space with subsequent sclerosis can control the fluid accumulation and relieve dyspnea. Another frequent cause of dyspnea in breast cancer patients is lymphangitic spread in the lungs. If there is no response to systemic therapy, there is no effective palliative therapy other than oxygen.

Breast cancer, along with lung cancer, frequently spreads to the pericardium and causes malignant pericardial effusions. The diagnosis is made by echocardiography and aspiration for cytology. Treatment is by drainage and instillation of sclerosing agents or by pericardectomy.

Breast cancer is one of the most common cancers to spread to the brain. The signs and symptoms are extremely varied and range from a mild memory loss with a normal neurologic exam to severe headaches, seizures, and focal findings. The diagnosis is made by the CAT scan. Treatment is with steroids and radiation therapy.

A second way breast cancer involves the central nervous system is by spread to the meninges, causing meningeal carcinomatosis. The symptoms are variable. The physical exam shows focal findings throughout the neuraxis that cannot be explained by a focal lesion. Diagnosis is made by lumbar puncture with cytology. Treatment is by direct instillation of drugs directly into the CSF via lumbar puncture or via an Ommaya reservoir. ■

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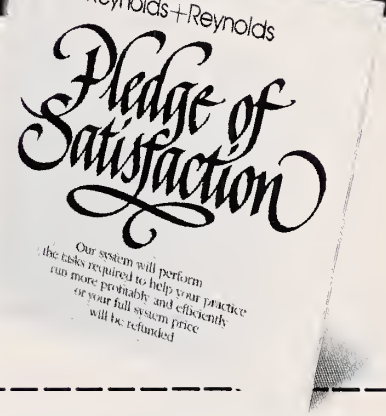


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# PSYCHOSOCIAL ASPECTS OF BREAST CANCER

*Rose F. McGee, Ph.D., Jane C. Clark, M.N., Ann T. Foltz, D.N.S.*

THE DIAGNOSIS of breast cancer is a stressful life event experienced by over 2,400 women in Georgia each year (American Cancer Society, 1987). Clinical observations of persons with cancer indicate that physiologic variables alone do not explain disease and treatment outcomes. That is, some persons whose prognosis should be excellent fail to survive and/or adjust and others whose prognosis is guarded do unseemingly well. The search for social and psychologic variables which may explain some of the differences in responses has been extensive. The discussion that follows is an overview of the research on the influence of psychosocial variables in women with breast cancer and the implication of research findings for cancer control and further research.

*An overview of the research on the influence of psychosocial variables in women with breast cancer and the implication of research findings for cancer control and further research.*

### Psychosocial Variables as Antecedents to Breast Cancer

Early studies on the influence of psychosocial variables on the occurrence of breast cancer were designed to predict breast biopsy results in women using a battery of standardized instruments and structured interview responses. Differences in loss of significant others and depression, hostility, IQ, dependency, and well-being scores between subjects subsequently diagnosed with benign and malignant breast disease were statistically non-significant (Greer & Morris, 1975; Schonfield, 1972).

However, Greer and Morris (1975) did report that patients with cancer tended to be "extreme suppressors." In later studies, suppression of emotion in general and anger specifically were found to be more prevalent among patients with positive breast biopsy results (Morris, Greer, Pettingale, & Watson, 1981; Wirsching, Stierlin, Hoffman, Weber, & Wirsching, 1982).

### Psychosocial Responses to Cancer Diagnosis and Treatment

Crisis theorists propose that effective resolution of a crisis results in a higher level of functioning than the precrisis state, while ineffective resolution leads to dysfunction (Caplan, 1964). A particularly vulnerable period for dysfunctional responses to cancer was identified by Weisman and Worden (1976) to be the first 100 days after diagnosis. For breast cancer patients, the period of vulnerability was extended. Data suggest that breast cancer patients may not begin to incorporate the surgical defect into their self-concept until 4 to 6 months postoperatively (Polivy, 1977; Quint, 1963; Ray, 1978). No doubt the trend toward more conservative primary surgical methods, breast reconstruction, and adjuvant chemotherapy has affected the length of the vulnerable period for breast cancer patients, although research on the quantitative and qualitative effects of such changes is limited. Research by Derogatis, Abeloff, and Melisaratos (1979) indicated that the vulnerable period does not end with the initial diagnosis and treatment phases. Long-term survivors of breast cancer were found to have higher levels of depression, anxiety, and psychologic distress than did short-term survivors.

Other factors which have been found to predispose to dysfunctional responses include prognosis and type of treatment. Taylor, Lichtman, Wood, Bluming, Dosik, and Leibowitz (1984) conducted a study using interview and retrospective chart review to document illness-related and treatment-related factors associated with psychosocial

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adjustment in breast cancer patients (N=78). Poor prognosis and more radical surgery were independent predictors of poor psychosocial adjustment, although the effect of type of surgery appeared to be mediated by the sense of disfigurement and changes in the sexual and affectional patterns in the marriage rather than by prognosis or disability. Similar findings were reported by Metzger, Rogers, and Bauman (1983) in a sample of 598 patients with distant metastasis. Sixty-six percent of this sample reported indications of possible clinical depression.

*In later studies, suppression of emotion in general and anger specifically were found to be more prevalent among patients with positive breast biopsy results.*

Patients on chemotherapy appear to be particularly susceptible to emotional distress and hopelessness. Meyerowitz, Sparks, and Spears (1979) reported emotional distress related to changes associated with chemotherapy in 94% of breast cancer patients, while increased hopelessness was noted among patients receiving chemotherapy with an external locus of control (Brandt, 1985).

Variables found to be associated with effective adjustment to breast cancer include personality variables and social support systems. The use of personality inventories to study responses to breast cancer indicated that persons with a "fighting spirit," rather than stoic acceptance of hopelessness/helplessness, had more favorable outcomes in terms of survival (Greer, Morris, & Pettingale, 1979). This finding was supported further by Speigel, Bloom, and Gottheil (1983) who found that breast cancer patients who had high expressiveness, low conflict, and low moral/religious orientation had the least mood disturbances post therapy.

Complementary to psychologic variables, social factors such as social support and social involvement and functioning have been shown to affect adjustment to and survival from breast cancer. Family support and style of coping have been shown to be predictors of positive adjustment to breast cancer (Bloom, 1982; Funch & Mettlin, 1982; Grandstaff, 1976; Jamison, Wellisch, & Pasnau, 1978; Meyerowitz, et al, 1979). Smith, Redman, Burns, and Sagert (1985) reported that the husband was the most important social support for married women, while relatives were the most important for single women. The most important types of support among the group of 272 breast cancer patients were emotional listening and talking about the illness. In contrast, data from 598 breast cancer patients indicate that marriage provided little protection against specific worries related to mastectomy (Metzger et al, 1983). Brandt (1985) reported that religious beliefs and perceived support were correlated positively with levels of hopelessness in a sample of breast cancer patients on chemotherapy (N=31). Although psychologic and social variables in response to breast cancer have been described, studies of the interrelationships among the variables and outcomes of the breast cancer experience are limited.

### Implications for Research and Practice

The most obvious implication of the findings cited is the need for further research. Human behavior is complex, yet most of the studies cited were single variable or limited in scope. Selye (1974) noted, "it is not the event, but what one does with the event" that determines the relationship between stressful experiences and either positive or negative outcomes. The mediating process between the stressor and the stress reaction is complex and is not reflected in most of the studies to date. To address some of the methodologic problems of stress research, Bloom, Pendergrass, and Burnell (1984) proposed to test a theoretical model of stress adaptation among patients with breast cancer. This study reflects the trend toward clustering of psychosocial variables to identify people at high risk for dysfunctional adjustment to breast cancer. Findings indicate that social support is the strongest predictor of coping response and has indirect effects on self-concept, sense of power, and psychologic distress.

Implications for practice can be inferred as well. First, the data indicate that the more expressive or assertive patient has less psychosocial problems. Does this finding suggest that the least likable patient may be less vulnerable and that the traditional expectations of stoicism and passive acceptance may be fostering maladaptive responses among breast cancer patients? Second, the data indicate that mood disturbances are not uncommon among breast cancer patients, yet how often are patients referred for counseling, to support groups, or prescribed antidepressants or tranquilizers to assist in dealing with the crises experienced? No one would advocate creating psychologic cripples, yet addressing the

*Does this finding suggest that the least likable patient may be less vulnerable and that the traditional expectations of stoicism and passive acceptance may be fostering maladaptive responses among breast cancer patients?*

cancer experience as a series of crises should foster the use of supportive therapy to assist patients through the stressful turning points of the illness.

The research also serves to identify high-risk groups for poor adjustment to breast cancer, i.e., patients receiving adjuvant chemotherapy and those lacking meaningful support within the family. If not recognized and treated appropriately, maladaptive psychosocial responses can contribute to noncompliance or discontinuance of therapy. For the patient on adjuvant therapy, the outcome may be life threatening. Other high-risk patients may be detected by closer attention to high-risk families.

Families are interdependent systems and stress within one member reverbrates throughout the system. A simple instrument to assist physicians in screening high-risk families is the family APGAR, a five-item scale developed by Smilkstein (1978). Referrals for family counseling may assist the patient and family to use the crises of cancer as growth promoting opportunities.

The scientist has a tendency to view the study of psychosocial variables as too "soft" and thus to ignore findings. This view does not seem warranted in light of advances in our understanding of human behavior and behavioral research techniques. Just as the practitioner does not wait for a cure for cancer to implement the best known plan of care, neither can professionals afford to wait for the definitive study of psychosocial responses to cancer to use the information currently available to help patients and their families adapt successfully to a diagnosis of breast cancer.

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# The Role of Radiation Therapy in the Treatment of Breast Cancer

*John Duttenhaver, M.D.*

## Introduction

X RAYS WERE DISCOVERED on November 8, 1895, by William Conrad Roentgen. Carcinoma of the breast became the first malignant disease to be treated by x-ray therapy when E. H. Grubbe, a Chicago layman manufacturer of vacuum tubes, treated a patient with carcinoma of the breast in January of 1896. The Curies discovered radium in 1896. Within 30 years after the initial discovery of radium, Dr. Geoffery Keynes, a British surgeon, had published data to demonstrate that long-term control of inoperable breast cancer could sometimes be obtained with the use of radium needles.[1] Despite 90 years of experience in treating cancer of the breast with radiation, the indications for the use of radiotherapy in breast cancer remain widely debated to this day. However, few would disagree that local irradiation can be a highly effective means of improving local tumor control for patients with carcinoma of the breast.

There are three broad areas where radiation therapy has been considered in the management of breast cancer: First, in patients with metastatic disease, radiotherapy can be effective in the palliation of disabling symptoms, particularly from bone and brain metastases. Secondly, in improving local control in the adjuvant setting following a mastectomy where pathologic examination of the resected breast and axillary contents shows tumor close to the deep resection margin or metastases in lymph nodes. Finally, as the major modality for primary control in patients deemed inoperable or in those undergong conservative surgery (lumpectomy).

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## The Role of Radiotherapy in Metastatic Disease

There is no dispute over the value of radiation therapy for patients with metastatic breast cancer. It has been used for decades as the treatment of choice in patients with painful bony metastases, offering relief of symptoms in approximately 90% of all cases, even though objective radiologic evidence of improvement is much less common.[2] A variety of regimes have been used, with the object of delivering effective and durable treatment as quickly as possible. Responses to treatment seem equally frequent regardless of site. There has been a slight trend in responsiveness as the dose of radiation rises from the short regimes of 2000 rads in five fractions to the longer schedules of 3000 to 4000 rads in 15 to 20 fractions.[3]

Ten percent of patients with advanced metastatic breast cancer will experience brain metastases and usually present with distressing neurologic symptoms. A randomized trial conducted by the Radiation Therapy Oncology Group found a median survival of only 6 months following radiation therapy for brain metastases.[4] Despite a short median survival, a significant number of patients survive far longer, and perhaps a third will survive beyond a year. However, the most important reason for offering a patient treatment is that the symptoms of raised intracranial pressure, focal cranial nerve palsies, ataxia, headaches, and visual disturbances are often rapidly reversible with radiation therapy. The quality of survival is significantly improved in patients who receive therapy compared to those who do not.

Two important neurologic problems posed by patients with metastatic breast cancer are spinal cord compression and choroidal metastases. The classic symptoms of spinal cord compression consist of back pain, weakness, and altered sensation in the legs and difficulties with micturition. Patients with choroidal metastases will often present with the sudden onset of unilateral or bilateral blindness. Both of these radiotherapeutic emergencies often respond in a

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**Table 1 — Local Regional Relapse Following Radical Mastectomy**

| Study | Pathologic Status: Positive Axillary Nodes | Pathologic Status: Negative Axillary Nodes |
|---|---|---|
| Valagussa* | 27% | 8% |
| Haagenson† | 19% | 3% |
| Fisher* | 25% | 4% |
| Spratt and Donnegan† | 26% | 6.5% |

* Only includes first site of relapse
† Does not include supraclavicular relapse

**Table 2 — 5-Year Results from the NSABP Trial Testing the Value of Post-Operative Radiation Therapy**

| Histologic Axillary Nodal Status | Relapse-Free Survival: Irradiated Patients | Relapse-Free Survival: Controls | Regional Recurrences: Irradiated Patients | Regional Recurrences: Controls |
|---|---|---|---|---|
| Negative | 78.6% | 76.0% | 0% | 2.1% |
| 1-3 Positive | 49.1% | 47.8% | 0% | 4.5% |
| 4 or More Positive | 28.4% | 18.0% | 1.5% | 12.5% |

dramatic fashion to radiation. The duration of neurologic compromise prior to the institution of therapy is the main determinate of outcome. Patients who are started on radiation therapy prior to 24 hours from the onset of symptoms usually improve neurologically. If neurologic deficits have been present for greater than 24 hours prior to the institution of radiation, then neurologic improvement is less common, although stabilization of the neurologic deficits can be obtained.[5, 6]

### Post-Mastectomy Radiation Therapy in Operable Breast Cancer

There is a significant incidence of local-regional relapse following radical mastectomy, especially if axillary nodes are involved with metastatic disease, Table 1.[7] Twenty to twenty-five percent of patients with positive nodes have a local failure after surgery when no adjuvant therapy is utilized. Mastectomy, even radical mastectomy, fails to remove internal mammary lymph nodes. In Handley's series, 223 of 1000 patients with operable breast cancer had positive biopsies of the internal mammary lymph nodes when they were sampled at the time of radical mastectomy.[8] Taken together, these data show that occult residual cancer frequently remains in the local regional area following mastectomy. One of the first major uses of radiation therapy in breast cancer was as an ancillary treatment following mastectomy.

There is now extensive published experience with post-operative radiation, and it has clearly demonstrated that well tolerated doses of radiation can eliminate occult residual deposits of breast cancer. The National Surgical Adjuvant Breast Project (NSABP) conducted a prospective randomized trial in which patients with early breast cancer were treated with radical mastectomy and then were randomly assigned to post-operative radiation to the regional lymph node areas or to a control group. The results of this study are shown in Table 2 and demonstrate that radiation clearly reduces regional relapses but does not have a statistically significant improvement on survival.[9] Two additional randomized trials have shown similar results.[10, 11]

These randomized trials showing no improvement in survival from the addition of post-operative irradiation were being published about the time that the results of early trials of adjuvant post-operative chemotherapy were being touted as showing significant improvement in survival. The wave of enthusiasm for adjuvant post-operative chemotherapy effectively eliminated the use of adjuvant post-operative irradiation during the late 1970s and early 1980s. As a result, most radiation oncologists are beginning to see large numbers of Stage II patients (positive lymph nodes) who are presenting with chest wall and nodal regional failures after receiving 6 to 12 months of aggressive multiagent chemotherapy. Additional surgery and radiation will only successfully salvage 50% of the cases who present with local regional failure following a mastectomy. Despite the thousands of women who have received multiagent chemotherapy in the adjuvant setting, there is a paucity of published data on the ability of adjuvant chemotherapy to control local disease in patients receiving post-mastectomy chemotherapy. In the Italian Series published by Bonadonna,[12] there was only a 3% improvement in local control in Stage II patients who received chemotherapy compared to those patients who underwent a mastectomy alone. In a retrospective analysis of patients from Georgetown University, adjuvant post-mastectomy chemotherapy in

*There is now extensive published experience with post-operative radiation, and it has clearly demonstrated that well tolerated doses of radiation can eliminate occult residual deposits of breast cancer.*

Stage II patients was found to slightly decrease the risk of local failure for patients with one to three lymph nodes involved. For patients with four or more nodes positive, the risk of local failure was identical in those patients who had undergone mastectomy alone compared to those patients who had undergone mastectomy followed by the addition of chemotherapy.[13] These data suggest that as the tumor burden increases, measured by an increasing number of positive lymph nodes, the ability of adjuvant chemotherapy to control local disease decreases.

The expected improvement in survival from the addition of post-mastectomy chemotherapy has been modest compared to early predictions.[12] We now need to reassess the role of adjuvant treatment, be it chemotherapy or radiation, in order to maximize the therapeutic benefit and minimize morbidity and mortality for the patients. The view that despite obvious improvements in local control, radiotherapy should not be routinely used since it does not affect survival, does not take into account the devastating morbidity of uncontrolled cancer on the chest wall and nodal regions. Until randomized trials have studied the issue further, patients with four or more axillary lymph nodes involved by metastatic cancer should receive post-operative irradiation to the chest wall and regional lymphatics since their risk of local failure remains approximately 20-25% following a mastectomy. It is unlikely that such radiation will result in a significant improvement in survival, but improved quality of life from prolonged local control will be a major improvement in the quality of patient care. With regard to axillary node negative patients, there may be some justification in considering post-operative irradiation, particularly in the group whose tumors are over three centimeters in diameter and who show evidence of high histologic grade, or those patients who have tumor within one to two millimeters of the deep resection margins at the time of mastectomy.

**Table 3 — Long-Term Survival Early Breast Cancer[16]**

| *Survival* | *Lumpectomy Plus Radiation* | *Mastectomy Plus Radiation* |
|---|---|---|
| 10 yr. | 65% | 51% |
| 20 yr. | 38% | 33% |
| 30 yr. | 22% | 18% |

### Lumpectomy and Radiotherapy as an Alternative to Mastectomy

The possibility of treating breast cancer by lumpectomy and radiation rather than mastectomy represents an exciting challenge, particularly since more women are now demanding a less radical surgical alternative whenever possible. Two of the earliest practitioners of radiation therapy for breast cancer were Baclesse[14] and Keynes.[1, 15] Baclesse at the Institut Curie was among the first to use high dose fractionated radiation therapy in the treatment of primary breast cancer. Baclesse reported a complete response rate of 59% at 1 year in 79 patients, most of whom received a total of greater than or equal to 6000 roentgen to primary tumors larger than 6 centimeters with or without edema.

Another approach to the delivery of high dose breast irradiation was the use of interstitial radium described by Keynes, a British surgeon. Beginning in 1922 with inoperable patients, he noted that complete responses could be obtained when up to 10 needles were inserted into the breast for 7 to 10 days. In 1937, Keynes reported on his 13 years of experience using interstitial radium and reported 5-year survival rates of patients with clinically uninvolved and involved axillary nodes of 71% and 29%, respectively. The corresponding figures from a matched series of surgically treated patients were 69% and 31%, respectively. Ten and 20-year follow up on the patients treated by Baclesse compared in a retrospective fashion to patients at the same institution treated by mastectomy showed that there were similar survival rates in the group treated with radiation and the group treated with surgery.

Although the foundations of contemporary radiotherapy are based on the results of these early workers, it was not until the development of super voltage equipment in the 1950s that it became feasible to consider radiation therapy as a primary treatment of breast cancer. The development of supervoltage equipment allowed for homogeneous distributions of radiation dose throughout the breast with relative skin sparing. These characteristics eliminated skin damage as the major dose limiting toxicity and permitted the delivery of higher doses of radiation to deeply situated tumors in the breast and axilla.

Within the last decade, multiple retrospective studies from France and North America have confirmed that lumpectomy followed by radiation to the breast yields survival results that are equivalent to both the radical and modified radical mastectomy in early breast cancer. In 1975, Vera Peters published a 30-year follow-up analysis of a retrospective matched pair study of 300 patients, half of whom were treated with excision biopsy plus radiation and the other half with some form of mastectomy (usually radical) also routinely followed by radiotherapy to the chest wall.[16] Patients were matched for age, stage, and grade of tumor, and at 30 years after treatment, no obvious advantage of survival could be demonstrated for patients undergoing mastectomy (Table 3). Peters even suggested that the more conservative treatment gave a slightly better survival. Since 1975, over a dozen major medical centers have published their retrospective analyses of several thousand patients treated with

tumorectomy and radiation and have confirmed that with 5, 10, and 20 years of follow up, the survival results and local controls rival the published results using the modified radical or radical mastectomy.[17-27]

*Taken together, the retrospective data and randomized trials clearly show that lumpectomy and radiation is equivalent to either the radical mastectomy or modified radical mastectomy in survival results and local control.*

These excellent results from retrospective analyses lead to the development of three randomized trials that have prospectively compared lumpectomy or quadrantectomy plus irradiation to mastectomy alone. One of these was conducted at the National Tumor Institute in Milan, Italy, in which patients with clinical T-1, N-0, M-0 breast cancer were randomized between quadrantectomy and axillary dissection with radiation or a Halsted radical mastectomy.[28, 29] There were 688 women studied in randomized trials between 1970 and 1980. The results were reported in 1985, with a maximum of 13 years of follow up and a minimum of 5 years. There are no significant differences in local recurrence, distant metastases or survival between the two treatment arms; however the quadrantectomy and radiation arm is continuing to show a 3% improvement in survival compared to the radical mastectomy arm. In the subset of patients with positive axillary nodes, a significant advantage in relapse-free survival is now seen for those treated by primary radiation therapy. Of note in this subset is for the greater part of that study, patients in both arms received CMF chemotherapy.

Another randomized trial involves 179 women at the Institute Gustave-Roussey in France comparing a modified radical mastectomy versus lumpectomy and radiation.[30] The median follow-up time is approximately 8½ years. Here, too, there are no significant differences noted in local recurrences or survival between the two groups. Again, the lumpectomy and radiation arm is showing a nonstatistically significant 3% improvement in disease-free recurrence.

*It is occasionally difficult to decide whether to treat systemically or locally as the initial therapeutic endeavor . . . it is more logical to employ a systemic treatment initially, reserving radical irradiation for painful metastases or for uncontrolled primary disease.*

In this country, the National Surgical Adjuvant Breast Project (NSABP) published the results of a three arm randomized study comparing the modified radical mastectomy versus lumpectomy alone, versus lumpectomy followed by breast irradiation.[31] Patients who were found to have pathologically involved lymph nodes were given adjuvant chemotherapy. With 39 months median follow up, the 5-year actuarial survival is equivalent in all three arms, with the lumpectomy and radiation doing the best. The local control rate in the lumpectomy alone arm is markedly inferior to the mastectomy or lumpectomy plus radiation arm.[30] Although the follow up in the NSABP study has been one of the major criticisms, there is no reason to suspect, based on the large published data from retrospective series and the 13-year experience from the Italian randomized trial, that the NSABP data will suddenly change.

The cosmetic result obtained with the technique of lumpectomy and radiation yields a good to excellent cosmetic result at 10 years in approximately 85% of the patients. Morbidity has been minimal and is comparable to that seen post-operatively following a mastectomy.[24] Second malignancies, which are a theoretical concern, have failed to materialize even in the series with 30 years of follow up. In 1987, there has yet to be a reported second malignancy attributable to the radiation in any patient who has undergone a lumpectomy and radiation.

Taken together, the retrospective data and randomized trials clearly show that lumpectomy and radiation is equivalent to either the radical mastectomy or modified radical mastectomy in survival results and local control. For most women, the psychologic advantage of maintaining the breast is a significant benefit to the lumpectomy and radiation. The cosmetic result is usually quite good following lumpectomy and radiation and contrasts significantly to the cosmetic deformity of a mastectomy. The psychologic morbidity and the cosmetic defect following mastectomy are often overlooked in the selection of therapy for patients.[32-34]

### The Role of Radiotherapy in Locally Advanced Breast Cancer

Unfortunately, there will always be patients deemed inoperable, who present with large lesions attached to the skin or underlying muscle (T-4) and patients whose medical ill health will preclude an operation. For these patients, radiation therapy usually in conjunction with chemotherapy is the treatment of choice. Most radiation therapists treat the whole breast and axilla and often include the internal mammary nodes and supraclavicular fossa. With modern radical radiation treatment, survival, even in advanced cases, is approximately 20% at 5 years. In a series by Fletcher and Monague, only 11% of these patients had local recurrence, even though many of the tumors were over 5 centimeters at the

time of presentation.[35] With these difficult tumors, it is generally accepted that increasing radiation doses are required for successful local control, usually in excess of 6000 rads in 6 to 7 weeks.

When patients present with widespread metastatic disease as well as an advanced local tumor, it is occasionally difficult to decide whether to treat systemically or locally as the initial therapeutic endeavor. Although therapy must be individualized for each case, it is more logical to employ a systemic treatment initially, reserving radical irradiation for painful metastases or for uncontrolled primary disease if the patient shows a worthwhile response to systemic treatment.

True inflammatory carcinomas of the breast pose particular problems, since these tumors are always by definition inoperable, and the whole breast must be considered at risk. Although localized skin involvement is not tantamount to a diagnosis of inflammatory carcinoma, these tumors are characterized by erythema, peau d'orange, and often by very rapid clinical evolution. Combined therapy utilizing chemotherapy, radiation, and palliative mastectomy should all be considered.

## Conclusions

Thirty years ago, the treatment of breast cancer was quite simple and noncontroversial. The increased complexity of therapeutic approaches in breast cancer has made it impossible for any single specialist to be knowledgeable in all areas of management. The radiation oncologist is best viewed as a member of the team that includes surgeons, medical oncologists, and pathologists who must work closely together in order to optimize the results of treatment and minimize morbidity.

Despite differences of opinion regarding the true role of post-mastectomy radiation to the chest wall and lymphatics, there is certainly no doubt as to the effectiveness of this approach in reducing the incidence of local recurrence. For metastatic disease, radiation therapy has an important role in eradicating painful and distressing symptoms.

Exciting results from Europe and the United States suggest that lumpectomy and radiation presents a real competitor to the mastectomy. As more women become aware of this alternative form of treatment, it seems likely that it will be practiced more widely.

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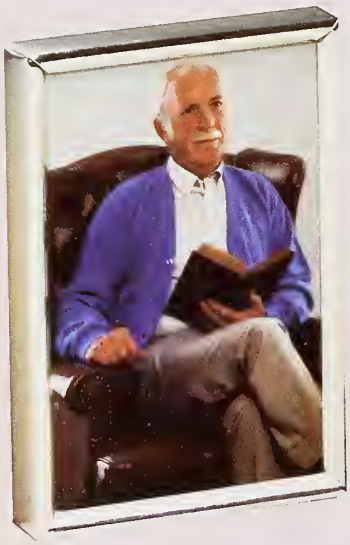

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Air Force Reserve ..... 354

Allscrips ..... 298

Atlanta Magnetic Imaging ..... 297

Ayerst Laboratories ..... 326A-D

Blue Cross/Blue Shield ..... 314

Campbell Laboratories ..... 327

Classifieds ..... 355

Family Practice Recertification ..... 324

Health Quip, Inc. ..... 322

King'sBridge ..... 297

Knoll Pharmaceutical ..... 354A-B, 355

Lilly, Eli & Company ..... 302A-B, 325-326

MAG Mutual Insurance Company ..... 296

Marion Laboratories, Inc. ..... 298A-B

Medic Computer Systems ..... 335

Reynolds & Reynolds ..... 345

Roche Laboratories ..... 322-323, 357-358

Upjohn Company ..... 302A

U.S. Air Force ..... 324

Weight Watchers of Greater Atlanta ..... 322

Woodridge Hospital ..... 327


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# CONTENTS

VOLUME 76, NUMBER 6

## FEATURES

GENERIC DRUGS — *CAVEAT EMPTOR?* 370
By Walter S. Feldman, M.D., J.D., F.C.L.M.

A NOTE TO PILL PURCHASERS 371
Harvard Medical School Health Letter

A PERSONAL PERSPECTIVE REGARDING MEDICAL ORGANIZATIONS 415
By William W. Moore, Jr., M.D.

## EDITOR'S CORNER

ON BEING REAL 365
By Charles R. Underwood, M.D.

## EDITORIAL

PHYSICIAN, WRITE, *"BRAND NECESSARY"* 368
By James A. Kaufmann, M.D.

## OFFICIAL PROCEEDINGS OF MAG'S 133rd HOUSE OF DELEGATES

FIRST GENERAL SESSION 372

FIRST SESSION — HOUSE OF DELEGATES 382

UNREFERRED REPORTS 388

SECOND SESSION — HOUSE OF DELEGATES 412

REPORT OF REFERENCE COMMITTEE A 417

REPORT OF REFERENCE COMMITTEE B 428

REPORT OF REFERENCE COMMITTEE C 443

REPORT OF REFERENCE COMMITTEE D 454

REPORT OF REFERENCE COMMITTEE F 461

REPORT OF REFERENCE COMMITTEE ON CONSTITUTION & BYLAWS (C&B) 471

## DEPARTMENTS

LETTERS TO THE EDITOR 364

PRESIDENT'S PAGE 366

ASSOCIATION NEWS 367

CALENDAR 378

INDEX TO ADVERTISING/ MANUSCRIPT INFORMATION 476

## COVER

A bird's eye view of the MAG's House of Delegates meeting last April at the Hyatt Ravinia in Atlanta.
Photo by Chuck Rogers, of Atlanta.

# Policy Regarding Sexual Contacts of AIDS Patients Needs Changing

I HAVE BEEN a proud member of AMA for 36 years and MAG for 10 years. During this time, we have always championed the cause of the sick and down-trodden, we have always fought to protect the health, lives, and welfare of the people of our country, and we have fought to keep the practice of medicine free from outside intervention. At the present time, however, I find it impossible to accept our stand on AIDS.

I am primarily a clinician, and I have always allowed others — the more articulate physician with more finesse and political acumen — to lead our great Association in making the right decisions which always considered the welfare of the patient and the freedom of the physician to practice medicine without outside intervention.

I firmly believe that the handling of the AIDS epidemic by CDC and the Public Health Service (PHS) will be remembered as the biggest mistake in the history of medicine.

By not following up on the sexual contacts of people with AIDS, people with ARC, and people with a positive AIDS virus antibody titer, we are knowingly permitting these infected people to transmit a universally fatal disease. This is not only bad medicine, but in my opinion, this is *criminal*. For 6 years, the CDC, PHS, and Gay Activists have been saying that "Education is the Answer." For 6 long years, they have been teaching and preaching to use safe sex practices, to be less promiscuous, to stay away from bathhouses and to not donate organs, semen, or blood.

The ineffectiveness of their educational program is reflected in a 300,000 per cent increase in AIDS. There are now an estimated 2,000,000 people infected, the incidence of AIDS cases is still doubling every year, the bathhouse in Atlanta is still open, and infected risk group members are still donating blood.

All of you clinicians know that human nature is such that until a person is screened and told that he/she is infected with a transmissable disease, the self denial instinct is so strong that the infected person will deny even to themselves that they are infected and continue to transmit the disease.

Syphilis ravaged the earth for about 450 years and was not controlled until Dr. Thomas Parran, Surgeon General of the United States, advocated the follow-up and screening of all contacts of infected people in the 1930s. With education, it takes several generations to make any inroads in the life styles and attitudes of the general public. With the AIDS epidemic, we do not have that much time. If each of the 2,000,000 people now infected and if each one of their contacts infects one person per year, by 1991 there could be 32,000,000 infected with the AIDS virus.

At the present time, we are not free to screen risk groups. We are not free to follow-up on contacts, we cannot screen people who are participating in contact sports, we are not free to screen food handlers, we are not free to screen premaritals or pregnant women. We are not free to practice good medicine without the fear of litigation.

Members of the MAG and AMA, I agree that the CDC and PHS have done outstanding work in past epidemics, b until we follow-up and screen contact this fatal disease will never be co trolled. Screening could and should b done confidentially.

How can we knowingly permit i fected people to infect and kill other

*Sincerely yours,*
*J. N. Gordon, M.D.*

# Teen Sex and Pregnancy

Dear Editor:

As a life member of the MAG, thoroughly enjoy the *Journal*. The are 2 articles on teenage pregnancy [ the March, 1987, issue]. I have a bett approach to this problem.

I have advocated an adult educati course for parents entitled, "Fami Living." This would embrace the b ology of sex, teenage pregnancy, dru alcohol and cigarette abuse, etc. T information received by the parents c then be discussed with the school chi in the privacy of the home. Our pare teacher organization can help organi such a course. This is one way to e hance parent child communicati sorely lacking these days. As a sid line, we make such a turn about scho prayer. Prayer begins in the home whe it belongs. In any event, good luck.

*Sincerely,*
*Henry Gall, M.D.*
*Retired Pediatrician*
*Cairo, Georgia*

# "On Being Real"

*"Generally, by the me you are Real, most f your hair has been ved off, and your eyes op out and you get lose the joints and very abby."*

THERE IS, HOPEFULLY, in each of us the child we once were. Not to the extent the childish behavior becomes our way of life but only that the complexities of our lives be leavened with the carefreeness, the levity, the happy unencumbered imaginative spirit of those childhood years. We need that honest playfulness with its clear eyed honesty to carry us through. Jean Kerr, the wife of theater critic Walter Kerr and author of *Please Don't Eat the Daisies,* told us about children's humor and reminded us of a quality that perhaps we too need to develop when she observed that, "The humor of children is different and amusing to us, for children see things as things are rather than things as they should be seen."

We had our annual gathering last April, our Annual Session of the MAG. During those 3 days, we looked at the many facets of our organization and the practice of medicine in general. We talked and discussed, argued and debated, "legislated" and made decisions which for good or ill will carry us through into the unpredictable future. Hopefully, they were good, honest, and valid decisions that will serve us well. It was the best wish of all of us that we performed, debated, and decided, as would mature men and women, but yet with a bit of the unhampered vision of the child in us. We were striving to be "real" persons during those gatherings this past month. We were striving, or should have been, to make *real,* honest decisions, *real* workable decisions, *real* realistic decisions.

It was Margery Williams who told us about becoming "real" when she wrote the children's book that many will remember called *The Velveteen Rabbit.* There is a place in that little volume where the young boy's play toys, the stuffed animals and the like, are having a conversation. The "Skin Horse" is talking to the "Velveteen Rabbit." The conversation goes like this:

> *"Real isn't how you are made, said the Skin Horse. "It's a thing that happens to you. When a child loves you for a long, long time, not just to play with, but really loves you, then you become Real. It doesn't happen all at once. You become. It takes a long time. That's why it doesn't often happen to people who break easily, or have sharp edges, or who have to be carefully kept. Generally, by the time you are Real, most of your hair has been loved off, and your eyes drop out and you get loose in the joints and very shabby. But those things don't matter at all, because once you are Real, you can't be ugly except to people who don't understand."*

And that, it seems to me, is what we were all striving for in this recently completed Annual Session. To not have too many sharp edges, for they tend to injure people. To not be too fragile, for we might fracture apart too quickly. To look with clear eyes and open minds and make valid decisions. To be "Real people." You will find the recordings of those deliberations scattered about in this issue of the *Journal.* Browse through them a bit, for there you will find yourself, your colleagues, your medical society in all of its deliberative grandeur, in all of its human foibles and frailty, in all of its intensity to be mature with the clear eyed vision of a child.

*Charles R. Underwood, M.D.*
*Editor*

# A View of the House

*Jack F. Menendez, M.D.*

THE ANNUAL SESSION of the MAG House of Delegates was held in Atlanta at the Hyatt Ravinia Hotel April 22-25, 1987. For the first time in many years, I was not involved in the planning and running of the Annual Session. I found, however, that the in-coming President has quite a busy schedule.

After arriving at the hotel Wednesday afternoon, I attended the Executive Committee meeting, viewing it with a new perspective, that of knowing that, as President, I would be chairing these meetings over the next year. Dr. John Watson has done a masterful job in chairing this Committee. He seems to do it effortlessly — the truly competent give that impression. Thursday, the Board of Directors, chaired by Dr. William Collins, met and gave consideration to the various items to come up at the Annual Session. There was lengthy discussion and input to the House from the Board of Directors.

The first General Session Thursday evening was a mixture of sadness at the reading of the list of members who had died during the past year and pride in our members who received awards for outstanding service. Our speaker for that session was Lt. Gov. Zell Miller who, at the end of his remarks, gave a very large gavel to our presiding speaker, Dr. James Kaufmann. Following the General Session, the First Session of the House of Delegates was convened. The officer elections were held and went smoothly, there being no contested races. Following the Thursday evening Session, Dr. Watson and I and our wives had dinner with Dr. John Foust, President of the North Carolina Medical Society, and his wife. I was invited to attend the Annual Meeting of the North Carolina Medical Society, which I did the week following our meeting.

Friday morning was the yearly GaMPAC breakfast. Our speaker was Senator Dale Bumpers of Arkansas, who gave a very witty and interesting talk. Following this, the Reference Committees met. I spent most of the day in Reference Committee D as well as visiting some of the other reference committees.

Saturday morning started early with my County Society Caucus. Following that, the Second Session of the House of Delegates convened. Reference Committee reports were given. I gave a short speech just prior to lunch, which was a call for help from our members who are not, at this time, active in our Association. I plan to continue this theme throughout the year.

I have always enjoyed the Friday Reference Committee hearings and the Saturday House Session, and th year was no exception. They represent democracy at its finest. T issues are important, and they are discussed frankly, openly, and completely in the Reference Committees. I am frequently reminded of the quote by John Stewart Mill, "truth is made more vivid by collision with error." The testimony given in the Reference Committees is heated, partisan, an directed, but always courteous. In this crucible, opinions mature and become clear and are considered a possible policy for the Association

As the Reference Committee reports are given at the House meeting on Saturday, they are agai discussed, amended as needed, an become MAG policy. In this "Proceedings issue" of the MAG *Journal,* those House actions are presented in their entirety.

In addition to the heavy load of business conducted at the House Meeting, there is also a time for fellowship by being with our coho from around the State and keeping with each other's activities and interests. The President's reception Saturday night was a fine affair an well attended.

I urge every member of our Association to attend an Annual Session. I think you will find it interesting and pertinent to the problems we all face in our practic

Jack F. Menendez

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## QUOTES

*Agreement makes us soft and complacent; disagreement brings out our strength. Our real enemies are the people who make us feel so good that we are slowly but inexorably pulled down into the quicksand of smugness and self-satisfaction.*
SYDNEY J. HARRIS

*Give to the world the best that you have and the best will come back to you.*
MADELINE BRIDGES

*To be trusted is a greater compliment than being loved.*
GEORGE MACDONALD

# *Physician, Write "BRAND NECESSARY"*

A SIGNIFICANT CHANGE recently enacted in the Georgia pharmacy law relating to generic drugs creates a new dimension of physician responsibility.

Here's what happened, and how it affects you.

In its last session, the General Assembly passed Senate Bill 289, which was introduced at the request of the Georgia Pharmaceutical Association. The new law, which takes effect on October 1, 1987, makes three changes regarding the substitution of generic drugs for brand-name pharmaceutical products:

First — The previously existing statute defined "pharmaceutically equivalent" drugs solely in terms of their active ingredients. The new law states that pharmaceutically equivalent drugs must contain "identical amounts of the identical active drug ingredient, in identical dosage forms, but not necessarily containing the same inactive ingredients."

Second — The previous law mandated that a physician *shall* instruct the pharmacist whether a generic drug may be substituted for a brand-name product. The new law states that the physician *may* instruct the pharmacist not to substitute a generic drug in lieu of a brand-name. To do so, the physician must, *in his or her own handwriting,* write the words "brand necessary" on the prescription form. (The prescriptions will not be valid if the words are pre-printed or stamped on the form.)

Third — The old statute dictated that medical prescription forms shall have two lines at the bottom for the prescribing physician's signature — either on the top line, beside "Generic Substitution Permitted" or on the bottom, alongside "Dispense as Written." The new statute abolishes this two-line format altogether and provides for a single line for the physician's signature.

What is the meaning of all this? It means that it is now much easier for a pharmacist to substitute generic drugs. The definition of "pharmaceutical equivalency" has been changed. The physician is no longer compelled to instruct a pharmacist whether to substitute a generic drug; the two lines relating to substitution and "as written" have even been removed from the prescription form. Moreover, if a physician wants to prevent generic substitution, he or she must remember to write "brand necessary" on every form he or she signs.

Let's take an example. For a brand-name product such as Elavil (50 milligrams), the pharmacist may pay $42.90 per hundred and might charge $49.00.* For a generic substitute, though, he or she may pay only $1.15 per hundred, and might charge the patient as much as $15.00.* By substituting, the pharmacist thus potentially increases his or her profits immensely while reducing the number of dollars tie up in inventory. Meanwhile, patie think they have saved money.

In evaluating the bill, MAG developed several concerns. First the potential physicians' liability when a pharmacist substitutes a generic drug. Though we could n document any physician malpracti suit arising from generic substituti federal law and FDA regulations state that "an FDA evaluation of therapeutic equivalents in no way relieves practitioners of their responsibilities in prescribing such products." Second, some contend that physicians may simply fail to write "brand necessary" on their prescriptions. By this inadvertent omission, they would be prescribi generic medication when actually they might have preferred a brand name product. Third, we were aw that generic drugs, even though evaluated as "therapeutically equivalent" to a brand-name prod may in fact vary in therapeutic effect. Variations are not only anticipated by the FDA, but variations of up to 30% are permi under federal law. Inactive ingredients, for instance, if not th same in the generic as in the bran name product, may increase or decrease absorption of the drug. Recently, the U.S. Congress mad less difficult to get generics on th market due to the Waxman Amendment.

This last consideration — the patient's well being — is most

* Wholesale prices derived from McKesson Item Catalogue, group buying rate of the Georgia Pharmaceutical Association.

ortant. Many of us have case eriences with poor generics. In practice, I do blood levels, when ropriate, on patients who take antin, Theo-Dur, procainamide, oxin, and quinidine. Based on my erience, I feel that the blood els for generic substitutes are erally lower than those for the ginal products. Because our office requires all patients to bring r medications on each visit, we l there are up to 10 to 20% uthorized substitutions under the sent two-line prescription system. n unaware at the present time of enforcement action that has been en against any pharmacist by the rmacy Board for this type of vity. Some stores never do this, le others may do it with some ilarity.

Iy personal experience with erics has not been good. I have n a medication which causes na. For this I took Lasix. I was Chicago at the AMA Leadership ference and took my "Lasix." first day I had no diuresis. The nd day I had no diuresis and eloped nausea. The third day the ptoms were the same. That noon I looked at the tablet, ch had appeared to be Lasix, and that the markings were different. ought the pharmacy had given me fferent drug. I immediately phoned Atlanta and told my macist, "You have given me the ng drug!" I thought it was a rent product. The pharmacist ed, "Read the markings to me." I did, and was told, "Oh . . . that is our generic for Lasix. I wasn't here the day it was filled, and my substitute pharmacist didn't realize that you don't take generics."

Our concern for patient welfare over less effective generics led us to be very cautious about the pharmacist's latitude in choosing a substitute drug. For a while, as the bill was being reviewed in committee, we had an agreement with the pharmacists that would have required substitution only if the drug were "an exact chemical and therapeutic equivalent." This would have made it very difficult to substitute poor-quality generics.

Then some pharmaceutical manufacturers entered the picture. Perhaps motivated by desire for profits brought by brand-name products and fearful that many doctors would forget to write "brand necessary," which was, of course, the pharmacists' basic assumption, on their new prescription forms, as well as the manufacturers' concern for patients welfare and the quality of some generics, drug companies lobbied intensively against S.B. 289, even with our amendment. The manufacturer's lobbyist not only made their pleas in the General Assembly but also worked at convincing individual physicians across our state that their best interest lay in opposing the bill. The vast majority of our members agreed. As a result, by the time S.B. 289 reached the House of Representatives, MAG formally opposed the bill.

Here I would add that our members should always be cautious when other groups attempt to lobby us. I urge you to contact a member of the MAG Legislative Committee or myself before being influenced by groups with motivations other than ours.

In the end, MAG's late opposition and change of position proved unsuccessful, as we had little opportunity to make our points effectively. On the issue of patient safety, manufacturers produced no documented evidence of patient jeopardy with generics. In fact, only one manufacturer even testified before the legislative committee. Furthermore, groups such as the American Association for Retired Persons, the State Merit System, and the Georgia Department of Medical Assistance lobbied heavily for Senate Bill 289 as great consumer legislation that would save millions of dollars. Some insurance companies also supported the bill as a means of reducing health care costs. Characterized thus as pro-consumer legislation designed to cut medical costs, S.B. 289 passed.

Under the new law, what should the physician do? If you are giving a patient a brand-name drug that is important to his or her welfare, unless it is a medication that is in the common domain (such as chloral hydrate or phenobarbital), you should prescribe carefully, always considering to write "BRAND NECESSARY."

*James A. Kaufmann, M.D.*
*Chairman*
*MAG Council on Legislation*

# Generic Drugs
## *Caveat Emptor?*

THE FOOD AND DRUG Administration (FDA) has announced that approximately 20% of all commercially available generic drugs are therapeutically inequivalent to the brand name product that they are designed to replace. Certified as "class B," these drugs are actually FDA-approved, but have not been found to be therapeutically equivalent. This designation is based upon prior evaluations, which required approval only on the basis of safety and efficiency rather than therapeutic equivalency.

Many of these drugs had been on the market for at least 23 years and many are still widely prescribed. The FDA has recommended that these particular generics, which include generic chlorpromazine, reserpine, prednisone, and prednisolone, not be substituted for brand name drugs. Unfortunately, such generic drugs are not branded with the FDA rating, and as a result this distinction remains largely unknown to the medical community and to their patients. In many cases the physician is not even aware which particular generic drug has been prescribed.

Furthermore, the FDA is presently prohibited from requiring the labeling of the therapeutic equivalency of generics, and generic drug manufacturers are prohibited from advertising a drug as an approved or "class A" product. Equally significant is the fact that not all generic drugs are interchangeable. A generic drug can actually vary 20-30% above or below the reference drug.

The FDA is presently in a legal dilemma. It has obtained essential information as required by Congress, but it is barred from appropriately transmitting this information to practicing physicians' and their patients.

Meanwhile, many funding agencies are required by law to contain costs and recommend the use of such generics, while other agencies prohibit their use. It may become the responsibility of dispensing pharmacists to inform patients about the substandard therapeutic equivalence of a specific generic.

This dilemma presents a potential of legal liability actions for physicians, which could be based upon allegations that a drug was prescribed that was rated as therapeutically inequivalent. It has been suggested that physicians protect themselves by cautioning patients about the potential problems with such generics.

The FDA generic rating manual is available from the Superintendent of Documents, Government Printing Office, Washington, DC 20402. The cost is $103.00.

*Walter S. Feldman, MD, JD, FCLM*

*(Reprinted from* Legal Aspects of Medicine, *April 1987, Volume 15, Number 4, p. 2.)*

# A Note to Pill Purchasers

BUYING DRUGS as generic rather than brand products does not guarantee a saving. In some instances, the generics even cost more than the brands. This information comes from an extensive study of nearly 900,000 prescriptions filled in 1,363 pharmacies in 39 states across the country. The price-per-pill of 21 pairs of brand and generic drugs was compared.

The amount of variation in price was itself surprising *(see table)*. And often enough, generic drugs were more expensive than their brand counterparts. Six times out of ten, conjugated estrogen (the generic hormone) was more expensive than Premarin (the brand); this was also the case with the diuretic furosemide (generic) and Lasix (the brand) at the strength usually prescribed. However, for the other 19 pharmaceuticals, the generic most often cost less than the brand.

The price-per-pill at different pharmacies showed rather astounding fluctuations. Four- or five-fold price differences were commonly observed with both types of product.

Even though generics as a whole had lower prices than brand names, the difference was often trivial. In part, this is because drug stores often mark up the generic version more than the brand. So the full wholesale saving often is not passed along to the retail purchaser.

On average, pill costs were lower in chain pharmacies than in independent ones, but this is only a rule of thumb, with many exceptions. The basic message of the study is that the price of a given drug varies widely, even in the same community, and that buying generic doesn't guarantee a saving.

**Examples of Drug Prices**

| *Generic/Brand* | *Pill Strength* | *Price per Pill to Consumer (Cents)* *Median* | *Range* |
|---|---|---|---|
| Conjugated estrogen | .625 mg | 12.7 | 7.0-34.7 |
| Premarin® | .625 mg | 12.7 | 9.9-32.1 |
| Indomethacin | 25 mg | 22.6 | 19.0-74.0 |
| Indocin® | 25 mg | 27.7 | 24.9-49.9 |
| Tolbutamide | 500 mg | 8.0 | 5.2-30.3 |
| Orinase® | 500 mg | 17.4 | 14.3-29.8 |
| Furosemide | 40 mg | 14.3 | 7.5-47.5 |
| Lasix® | 40 mg | 15.6 | 11.9-46.0 |
| Chlordiazepoxide | 5 mg | 6.6 | 4.1-29.9 |
| Librium® | 5 mg | 13.8 | 11.5-34.3 |

(Reprinted from *Harvard Medical School Health Letter* May 1987;12(7):5 which adapted it from B. S. Bloom, D. J. Wierz, and M. V. Pauly, "Cost and price of comparable branded and generic pharmaceuticals," *Journal of the American Medical Association* 256:2523-2530, November 14, 1986.)

# Summary of the Proceedings of the 133rd House of Delegates

April 23-25, 1987
Atlanta

## CALL TO ORDER

THE FIRST GENERAL SESSION of the 133rd Annual Session of the Medical Association of Georgia was called to order by the President, John D. Watson, Jr., M.D., of Columbus, at 7:00 P.M., Thursday, April 23, 1987, in the Regency Ballrooms of the Hyatt Hotel at Ravinia, Atlanta. Dr. Watson introduced Dr. O. Wytch Stubbs, Jr., of Tucker, who delivered the invocation.

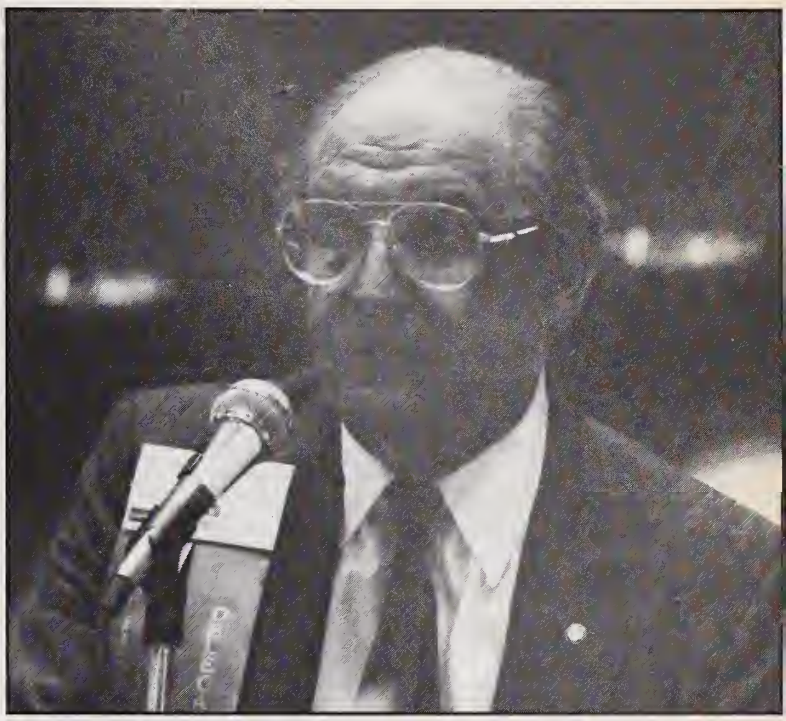
Dr. Watson introduced Mrs. John G. Bates who sang the National Anthem (accompanied by Mrs. John Anderson) and led the audience in the Pledge of Allegiance. Dr. Watson extended a warm welcome to all attending the Annual Session, and introduced Dr. Gwynne Brunt, President of the Medical Association of Atlanta, our host for this year's Annual Session. On behalf of the members of the Medical Association of Atlanta, Dr. Brunt welcomed the audience to Atlanta.

Dr. Watson introduced the President of the DeKalb County Medical Society, Dr. Frank Matthews, who expressed a sincere welcome to all on behalf of the members of the DeKalb County Medical Society. Dr. Matthews then introduced Manual Maloof, Chief Executive Officer of DeKalb County, who extended a warm welcome to the attendees and thanked MAG for holding its Annual Session in DeKalb County.

## MEMORIAL SERVICE

The audience stood in respect as Dr. Watson read the names of those members who have died since the 1986 Annual Session.

Included were: Theodore F. Atkinson, Macon; John P. Avera, Brunswick; Hugh J. Bickerstaff, Columbus; B. C. Blaine, Atlanta; John C. Blalock, Atlanta; Hubert H. Blanchard, Griffin; James W. Brantley, Atlanta; John Bush, Columbus; T. J. Busey, Fayetteville; Albert W. Carter, Jr., Atlanta; A. H. Center, Savannah Amey Chappell, Atlanta; Gerald B. Creagh, Athens; Ray E. Dellinger, Marietta; Lorenzo Del Portillo, Coral Gables, FL; William R. Domingos, Macon; Edgar J. Filson, Savannah; Evan Frederickson, Atlanta; Andreas R. Gruentzig, Atlanta; Warren H. Gullen, Augusta; Louis R. Harvey, Andersville; E. A. Hensley, Conyers;



*SPEAKER OF THE HOUSE,*
*James A. Kaufmann, of Atlanta.*

John C. Ivey, Meansville; Lewis E. Jones, Atlanta; Alvin D. Josephs, Atlanta; Dan B. Kahle, Atlanta; Clifton G. Kemper, Atlanta; J. H. Kite, Jacksonville, FL; Donald M. Kurtz, Columbus; Howard B. Lee, Decatur; W. R. McGinty, Moultrie; Thomas A. McGoldrick, Jr., Savannah; E. C. McMillan, Jr., Macon; W. Swanson Millians, Atlanta; Joseph H. Moorhead, Atlanta; E. A. Musarra, Marietta; Richard W. Nysewander, Tucker; Joseph Pacifici, Savannah; J. R. Paulk, Moultrie; Julian K. Quattlebaum, Savannah; John C. Reedy, Atlanta; Enos J. Reilly, Marietta; Robert E. L. Shumate, Columbus; Malcolm M. Smith, McRae; Robert W. Smith, Atlanta; Henry Steadman, Atlanta; Russell Thomas, Americus; Margaret A. Thornton, Atlanta; Nelson O. Tyrone, Jr., Columbus; John Van Duyn, Columbus; John C. Withington, Savannah; James A. Woodall, Thomaston.

Dr. Watson presented Mrs. Charles Andrews with a special memorial to Charles R. Andrews, M.D., and expressed sincerest admiration and gratitude for the life and service of Dr. Andrews.

CERTIFICATES OF APPRECIATION

Certificates of Appreciation were presented to those members who have been active in Association affairs and have made special contributions to Medicine and to the Medical Association of Georgia.

Certificates were awarded to the following people: John D. Watson, Jr., M.D., MAG President (1986-87); Charles R. Underwood, M.D., MAG First Vice-President (1986-87); Joe L. Nettles, M.D., MAG Second Vice-President (1986-87); Ralph A. Tillman, M.D., MAG Secretary (1985-87); Mrs. William C. (Barbara) Tippins, Jr., President, MAG Auxiliary (1986-87); S. Boyd Eaton, M.D., Chairman, MAG Committee on Health Education (1984-86); Eloise Sherman, M.D., Frank Middleton, M.D., Mrs. Dan Bateman, Bob R. Maughon, M.D., Harry Cheves, M.D., Mrs. William McDavid, Mrs. Leroy Rabb, Samuel Goodrich, M.D., Mrs. Milton Johnson, Robert Simmons, M.D., William R. Anderson, M.D., Leon Curry, M.D., Mrs. William Christian, and Larkus Pesnell, M.D., Members, GaMPAC Board of Directors; Herbert S. Alden, M.D., Contributing Editor, *JMAG* (1954-86); Preston D. Ellington, M.D., Contributing Editor, *JMAG* (1959-86); J. Willis Hurst, M.D., Contributing Editor, *JMAG* (1956-86); William R. Kenny, M.D., Contributing Editor, *JMAG* (1982-86); Donald J. McKenzie, M.D., Contributing Editor, *JMAG* (1973-86); Jack A. Raines, M.D., Contributing Editor, *JMAG* (1979-86); Patrick C. Shea, Jr., M.D., Contributing Editor, *JMAG* (1954-86); A. Calhoun Witham, M.D., Contributing Editor, *JMAG* (1977-86); Mrs. William C. (Jan) Collins, Chairman, A-MAG Legislative Committee (1984-87); Eleanor Richardson, Jim Pannell, George Hooks, Tom Wilder, Georgia State Representatives concerned with the preservation of quality medical care; Tommy Olmstead, Frank Albert, Georgia State Senators concerned with the preservation of quality medical care; and E. C. Evans, M.D., Chairman, Medical Practice Committee (1985-87).

FIFTY-YEAR MEMBERS

The following physicians were

honored for having practiced medicine for 50 years or more: Robert L. Berry, Villa Rica; F. Phinizy Calhoun, Jr., Atlanta; Alfred O. Colquitt, Jr., Marietta; George R. Connor, Columbus; James B. Craig, Milledgeville; Albert L. Evans, Atlanta; James A. Green, Athens; Nathan I. Gershon, Atlanta; William H. Grimes, Atlanta; Frank N. H. Harrison, Atlanta; Lamont Henry, Atlanta; William D. Jarratt, Jr., Macon; William Leonard, Atlanta; Robert B. Logue, Atlanta; Louis H. McDonald, Atlanta; Robert C. McGahee, Augusta, Haywood L. Moore, St. Simons Island; Robert F. Norton, Rome; Elton S. Osborne, Jr., Atlanta; Samuel E. Patton, Macon; R. F. Payne, Augusta; Hal S. Raper, Warm Springs; J. Robert Rinker, Augusta; J. Victor Roule, Augusta; Meyer M. Schneider, Savannah; Charles W. Smith, Atlanta; Charles F. Stone, Jr., Atlanta; Robert D. Walter, Calhoun; William A. Wilkes, Augusta; Charles R. Williams, Wadley; and James W. Yoemans, Jesup.

*FOR HIS LOYAL SUPPORT of and friendship with the medical community throughout Georgia, Lt. Gov. Zell Miller (L) is honored by MAG and presented with a gift by President John D. Watson, Jr.*

LIFE MEMBERS

Dr. Watson announced that the following members had been awarded Life Membership in the Medical Association of Georgia: M. C. Adair, M.D., Washington; Eugene D. Bell, M.D., Douglas; R. A. Chipman, M.D., Columbus; Remer Y. Clark, M.D., Marietta; F. N. Harrison, M.D., Augusta; John P. Jones, M.D., Macon; Leon Lapides, M.D., Columbus; John T. Leslie, M.D., Avandale Estates; William H. Lippitt, M.D., Savannah; John M. Martin, M.D., Augusta; Lawrence P. Matthews, M.D., Atlanta; Chester W. Morse, M.D., Decatur; August J. Nardone, M.D., Avondale Estates; J. B. Rabun, M.D., Savannah; C. L. Ridley, Jr., M.D., Macon; L. J. Roberts, M.D., Columbus; John M. Schreeder, M.D., Chamblee; Robert A. Sears, M.D., Macon; Will C. Sealy, M.D., Macon; T. O. Vinson, M.D., Atlanta; Asa G. Yancey, M.D., Atlanta; and George Zubowicz, M.D., Columbus.

AMA-ERF CHECKS

Each year, the American Medical Association-Education Research Foundation distributes funds collected, in large part, by the Auxiliary of the AMA and its various organizations. Mrs. Dempsey Brown of Macon, Chairman of the A-MAG AMA-ERF, and Mrs. William C. Tippins, President of A-MAG, assisted Dr. Watson in the presentation of money raised in Georgia to our four medical schools, as follows: Medical College of Georgia — $32,065.14; Emory University School of Medicine — $21,602.51; School of Medicine of Morehouse College — $6,488.02; and Mercer University School of Medicine — $5,084.49.

REPORT OF THE AUXILIARY

Mrs. William C. Tippens, President of A-MAG, presented the ac-

*SPEAKER OF THE HOUSE James A. Kaufmann (R) is presented with a gavel by Lt. Gov. Zell Miller at the opening of the First General Session to assist him in conducting the business of the House.*

tivities and services provided by the Auxiliary this past year. Her written report is filed elsewhere in this *Journal.*

INTRODUCTION OF GUEST SPEAKER

The following remarks were made by Dr. Watson as he introduced our guest speaker: "There is no greater honor that can be bestowed upon me, as President of the Medical Association of Georgia or as a true Georgian, than the privilege of introducing to you our 1987 Annual Session guest speaker.

Zell Miller, as a State Senator many years ago, was Chairman of the Senate Health and Welfare Committee, where he sought out the opinions of the physicians of Georgia on all medical issues that went

*AUXILIARY PRESIDENT Barbara Tippins (Mrs. William C.), after being introduced by MAG President Watson, reported to the First General Session of the House about the activities and accomplishments of the Auxiliary.*

*RECIPIENT of MAG's Distinguished Service Award is Charles D. Hollis, Jr. (R), an internist from Albany. Dr. Hollis is in private practice and serves as President, Chairman of the Board, and is one of the original founders of MAG Mutual Insurance Company. He received this Award for his meritorious and distinguished service reflecting credit and honor on the Association.*

*PETER L. SCARDINO (R), a urologist from Savannah, received MAG's Civic Endeavor Award for his outstanding public service and participation in civic activities. Pictured with him is President Watson.*

before that Committee. In his position working for two previous Governors, he made sure that the quality of Georgia's health care was a primary issue, and that the MAG was the authority on quality health care in Georgia.

As our greatest Lt. Governor, Zell Miller has continued his commitment to insure all Georgians the highest quality of medical care and has continued to seek guidance and advice from our Association.

He was the *only* state public official who recognized the plight of, not only the physician, but the small businessman, the county government, and all Georgia consumers of goods and services as they related to the liability crisis. And he was the only official willing to step forward and tell the State — tell the Governor — tell the Speaker of the House — and tell the trial lawyers of Georgia that Tort Reform 1987 *would* pass.

Through his numerous public statements during the spring, summer and fall of 1986, he successfully challenged the opponents of Tort Reform.

Principally through Zell Miller's efforts, the Governor appointed a task force to develop an acceptable package of Tort Reform. As a result, the Lt. Governor's bill became a joint Governor/Lt. Governor's bill. Ninety-five percent of that bill has now become law.

At this time, I'd like to introduce to you a true friend of all the people of Georgia; and a true friend of all physicians in Georgia; my friend and yours, Lt. Governor Zell Miller."

PRESENTATION OF AWARDS

**Charles D. Hollis, Jr., M.D.,** was awarded MAG's *Distinguished Service Award,* and **Peter L. Scardino, M.D.,** of Savannah, was the recipient of the *Civic Endeavor Award.* **John P. Heard, M.D.,** of Decatur, was honored as the *Family Physician of the Year.*

DR. HOLLIS, an internist from Albany, received the Distinguished Service Award for meritorious and distinguished service reflecting credit and honor on the Association. He is in private practice and serves as the President, Chairman of the Board, and one of the original founders of the MAG Mutual Insurance Company. He is a delegate to the American Medical

Association from Georgia and his past record has been distinguished as President of the Medical Association of Georgia; President of the Dougherty County Medical Society; President of the Georgia Society of Internal Medicine; President of the staff of Phoebe Putney Memorial Hospital in Albany; and President of the staff of HCA Palmyra Medical Center in Albany. Other positions Dr. Hollis has held include Chairman of the Governor's Advisory Council on Medical Malpractice; member of the Board of Directors of Blue Shield of Columbus; Chairman of the Allied Health Professionals Committee of the American Society of Internal Medicine; Chairman of the PSRO Committee of the Medical Association of Georgia; and member of the Joint Review Committee on Accreditation of Physician Assistant Training Programs of the American Medical Association. Locally, Dr. Hollis is a member of the Rotary Club, is former Vice President of the YMCA and is a former member of the Administrative Board of the First United Methodist Church in Albany. Dr. Hollis is certified by the American Board of Internal Medicine and holds a Fellowship in cardiology at the University of Minnesota National Health Institute.

*JOHN P. HEARD, of Decatur, was honored as the Family Physician of the Year for being a leader in his profession as well as his community. Presenting the award on the left is Richard A. Wherry, a family practitioner from Dahlonega.*

DR. SCARDINO, a urologist in Savannah, received MAG's Civic Endeavor Award for his outstanding public service and participation in civic activities. Professionally, he has served as President of the Georgia Urological Association; President of the Georgia Medical Society; Chairman of the Education Council of the American Urological Association; and as a former examiner of the American Board of Urology.

In his community, Dr. Scardino has served as President of the Savannah Symphony Society, and the Rotary and Maderia Clubs of Savannah. He has also held membership positions on the Telfair Academy of Arts and Sciences Board of Trustees and the Chatham County Board of Education.

Dr. Scardino has also been honored with the Gignilliat Trophey for Culture by the City of Savannah. His civic activities represent physicians at their finest, serving humanity not only through medicine, but also in his community activities.

DR. JOHN P. HEARD, a family physician from Decatur, received the Family Physician of the Year Award for being a leader in his profession, as well as his community.

Dr. Heard received his training from the Emory University School of Medicine and completed his residence at the University of Louisville.

Dr. Heard has practiced medicine for over 33 years in Decatur. His community activities range from being a father of 3 children to teaching sex education in the DeKalb County School System for fifteen years. He is also team physician for Decatur High School. Dr. Heard serves on the Board of Directors of the DeKalb Chamber of Commerce and actively participates in the Republican Party.

Dr. Heard received the Citizenship Award from the DeKalb County Medical Society; Certificate of Appreciation from the DeKalb Y.M.C.A. and from the Medical Association of Georgia. He is active in the medical community having served as Chairman of the Public Relations Committee and on the Board of Directors of MAG. Dr. Heard served as President in 1973 and member of the Board of Trustees of the DeKalb Medical Society.

Currently, Dr. Heard serves on the Board of Directors of the MAG Mutual Insurance Company. He has been a member of the GAFP since 1970 and American Academy of Family Physicians.

ADJOURNMENT

Following several brief announcements, Dr. Watson adjourned the First General Session at 10:00 P.M.

# CALENDAR

## JUNE

29-July 2 — *Kiawah Island, SC:* **Hematology-Oncology Symposium.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

## JULY

7-10 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

9-11 — *Kiawah Island, SC:* **7th Annual Clinical Obstetrics.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

10-11 — *Savannah:* **SMA's Clinical Postgraduate Conference.** Category 1 credit. Contact Jeanette Stone, SMA, P.O. Box 190088, Birmingham, AL 35219-0088. PH:205/945-1840.

13-16 — *Kiawah Island, SC:* **Clinical Cardiology.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

21-25 — *Kiawah Island, S.C:* **10th Annual Critical Care Medicine.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

27-29 — *Kiawah Island, SC:* **10th Annual Pediatric Update 1987.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

27-29 — *Atlanta:* **American Hospital Association.** Contact AHA Office, 36 S. State St., Salt Lake City, UT 84111.

27-30 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

## AUGUST

2-5 — *Atlanta:* **International Society for STD Research.** Category 1 credit. Contact: Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

3-8 — *Hilton Head Island, SC:* **12th Annual Your Practice, Your Money, Your Family.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

10-14 — *Atlanta:* **Summer Imaging and Interventional Techniques V.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

13-16 — *Hilton Head Island, SC:* **Ga. Psychiatric Association's Summer Meeting.** Category 1 credit. Contact James Moffett, Dir. of Specialty Society Relations, MAG, 938 Peachtree St., Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

17-21 — *Atlanta:* **A Comprehensive Board Review in Internal Medicine.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

20-23 — *Kiawah Island, SC:* **Pulmonary Disease Review.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

24-28 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

29-30 — *Callaway Gardens:* **Joint Meeting of the Ga. Society of Anesthesiologists and the Alabama Society of Anesthesiologists.** Category 1 credit. Contact Ronald W. Dunbar, M.D., Program Chairman, Dept. of Anesth., Emor Univ. Hosp., 1465 Clifton Rd., Atlanta 30322. PH:404/321-0111 e 3900.

## SEPTEMBER

4-6 — *Sea Island:* **Ga. Society of Internal Med. & Ga. Chapter, Amer. Coll. of Phys. Joint Meeting.** Category 1 credit. Contac Milton Frank, MD, GSIM, 1372 Peachtree St., Ste. 301, Atlanta 30309 (PH:404/892-2131) or Mark Silverman, MD, Ga. Chapter, ACP 1968 Peachtree Rd., Atlanta 30309 (PH:404/350-3368).

4-6 — *Sea Island:* **Georgia Gastroenterologic Society.** Categor 1 credit. Contact Steve Morris, M.D., 25 Prescott St., Atlanta. PH:404/881-1094.

17-19 — *Hilton Head Island, SC:* **9th Annual Frontiers in Nutrition.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

17-19 — *Sea Island:* **Georgia Surgical Society Annual Meeting.** Category 1 credit. Contact William C. McGarity, M.D., Secy.-Treas., GSS, Dept. of Surgery, 1365 Clifto Rd., Atlanta 30322. PH:404/321-0111.

17-19 — *Savannah:* **11th Annual Neonatology — The Sick Newborn** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

20-23 — *Hilton Head Island, SC:* **Georgia Obstetrical and Gynecological Society, Inc.** Contac Chester C. Lane, Executive Director 69 Butler St., Atlanta 30303. PH:404/659-0289.

28-Oct. 2 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404 727-5695.

# *Would You Call This A Healthy Practice?*

The UAB Medical Center, through the Center for Health Professionals, is the first academic medical center in the nation to offer a chemical dependency treatment program designed *by* health professionals, *for* health professionals and their special needs.

The Center for Health Professionals is a results oriented therapeutic community designed exclusively for physicians, dentists and other health professionals impaired by the abuse of alcohol or other drugs. The UAB Medical Center, internationally known for its contributions to excellence in the clinical practice of medicine has committed the same effort to the Center for Health Professionals.

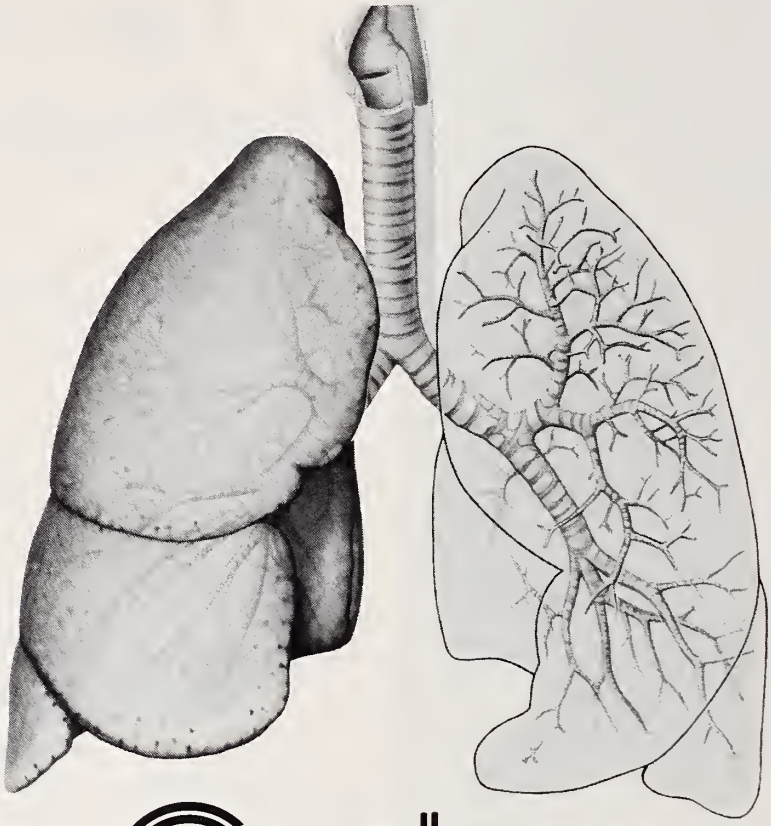
The priority at the Center is to provide the finest treatment possible. And to do so, it offers comprehensive inpatient care, outpatient follow-up services, family programs and retraining, all individualized to meet the needs of each patient. If necessary subspecialty care can be provided by the faculty of the UAB Medical Center.

For privacy and confidentiality, the Center is nestled in a secluded wooded setting, south of Birmingham, Alabama. Although our facility is new, our commitment to health care professionals is well established.

To receive more information in complete confidence, fill in and return the attached postage-paid reply card or call our toll-free telephone number today: 1-800-452-9860 and ask for the Center for Health Professionals.

**UAB** Medical Center
***Center for Health Professionals***

# Consider the causative organisms...



# Ceclor®
## cefaclor

## 250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

*Haemophilus influenzae, Streptococcus pneumoniae*
(ampicillin-susceptible and ampicillin-resistant)

*Note:* Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

**Summary. Consult the package literature for prescribing information.**

**Indications:** Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A $\beta$-hemolytic streptococci).

**Contraindication:**
Known allergy to cephalosporins.

**Warnings:**
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

**Precautions:**
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

**Adverse Reactions:** (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

**Abnormalities in laboratory results of uncertain etiology**
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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*Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.*

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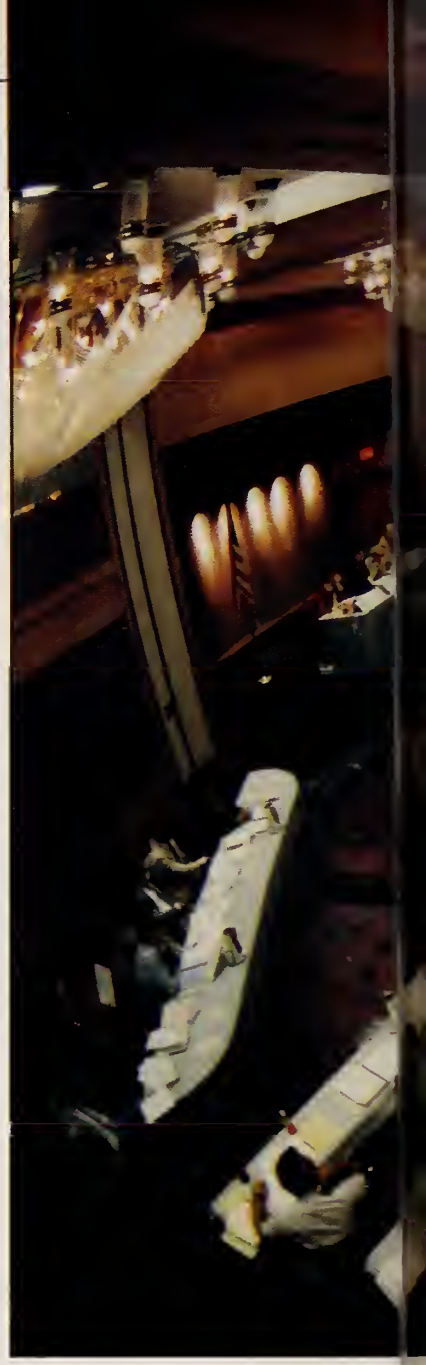


# FIRST SESSION

## House of Delegates

### Thursday, April 23, 1987

THE FIRST SESSION of the MAG House of Delegates was called to order by the Speakers of the House, James A. Kaufmann, M.D., at 7:30 P.M., Thursday, April 23, 1987, in the Regency Ballrooms of the Hyatt Hotel at Ravinia, Atlanta, Georgia. Jack A. Raines, M.D., Columbus, served as Vice-Speaker of the House.

The Speaker called for a report from the Credentials Committee which was given by James H. Sullivan, M.D. Dr. Sullivan reported that 140 delegates representing 38 component county medical societies were in attendance and accordingly, announced a quorum of the House of Delegates was present.

DELEGATE ATTENDANCE

William E. Adams, M.D., Lawrence Lanier Allen, M.D., Stephen C. Allen, M.D., Fred L. Allman, M.D., Patrick L. Anders, M.D., Robert H. Anderson, Jr., M.D., Thomas J. Anderson, Jr., M.D., Catherine S. Andrews, M.D., Harold Asher, M.D., James L. Askew, M.D., Sam O. Atkins, M.D., James E. Averett, Jr., M.D., Joseph P. Bailey, M.D., Julia E. Ballard, M.D., William E. Barfield, Sr., M.D., J. Dan Bateman, M.D., John G. Bates, M.D., James F. Beattie, Jr., M.D., Regina Benjamin, M.D., John F. Bigger, Jr., M.D., William H. Biggers, M.D., H. Duane Blair, M.D., Allan C. Bleich, M.D., David C. Bosshardt, M.D., Robert G. Bradbury, M.D., Rupert H. Bramblett, M.D., Spencer S. Brewer, Jr., M.D., Larry Brightwell, M.D., L. E.

Brown, M.D., Rodney M. Browne, M.D., Gwynne T. Brunt, Jr., M.D., L. C. Buchanan, M.D., William L. Buhrow, M.D., Dan Burge, M.D., Billy D. Burk, M.D., Robert A. Burns, M.D., William B. Burns, Jr., M.D., E. Napier Burson, Jr., M.D., Leon H. Bush, M.D., Rodrigo Cabezas, M.D., Louis G. Cacchioli, M.D., Donald H. Campbell, M.D., H. Deitz Carpenter, Jr., M.D., Albert A. Carr, M.D., A. Bleakley Chandler, M.D., H. L. Cheves, M.D., S. William Clark, Jr., M.D., Teresa E. Clark, M.D., Marvyn D. Cohen, M.D., Michael J. Cohen, M.D., Richard W. Cohen, M.D., Thomas A. Collentine, M.D., Chappell A. Collins, Jr., M.D., William C. Collins, M.D., Don R. Connell, M.D., Leon E. Curry, M.D., John W. Darden, M.D., Robert L. Davies, M.D., Alfred L. Davis, Jr., M.D., Dave M. Davis, M.D., Floyd E. Davis, M.D., H. G. Davis, Jr., M.D., R. Carter Davis, Jr., M.D., John I. Dickinson, M.D., Sammie Dixon, M.D., F. William Dowda, M.D., Richard E. DuBois, M.D., M. Julian Duttera, Jr., M.D., S. Boyd Eaton, M.D., J. W. Estes, M.D., E. C. Evans, M.D., J. Patrick Evans, M.D., Louis H. Felder, M.D., Daniel M. Feldman, M.D., Sumner Fishbein, M.D., Henry A. Foster, M.D., David J. Frolich, M.D., Stefan H. Fromm, M.D., Norman P. Gardner, M.D., Kenneth L. Goldman, M.D., Robert D. Gongaware, M.D., James S. Goodlet, M.D., Joseph W. Griffin, Jr., M.D., Michael A. Haberman, M.D., O. Emerson Ham, Jr., M.D., Carl V. Hancock, Jr., M.D., Buford G. Harbin, M.D., Wil-

liam R. Hardcastle, M.D., Charles E. Harrison, Jr., M.D., J. Harold Harrison, M.D., J. Rhodes Haverty, M.D., William M. Headley, M.D., John P. Heard, M.D., William C. Heard, M.D., Irving D. Hellenga, M.D., E. V. Herrin, M.D., Hugh O. Hodges, M.D.

Emory W. Holloway, Jr., M.D., Anthony F. Isele, M.D., Philip Z. Israel, M.D., Joseph M. Jackson, M.D., C. E. Johnson, Jr., M.D., Milton I. Johnson, Jr., M.D., Fleming L. Jolley, M.D., William B. Jones, M.D., James A. Kaufmann, M.D., Ellis B. Keener, M.D., William F. Keeton, M.D., Chang Kim, M.D., C. Peter Lampros, M.D., Charles A. Lanford, M.D., Bob G. Lanier, M.D., J. Moultrie Lee, M.D., Walter M. Ligon, M.D., William D. Logan, Jr., M.D., Juanita Y. Lott, M.D., Gary R. Loveless, M.D., Johann R. Manning, M.D., Joe B. Massey, M.D., W. Frank Matthews, M.D., Alva Louie Mayes, Jr., M.D., Charles W. McDowell, Jr., M.D., Virgle W. McEver, Jr., M.D., LaMar S. McGinnis, Jr., M.D., Ray L. McKinney, M.D., Jack F. Menendez, M.D., Arthur J. Merrill, Jr., M.D., Frank F. Middleton, III, M.D., John R. Molinaro, M.D., E. M. Molnar, M.D., W. W. Moore, Jr., M.D., Hugo S. Moreno, M.D., René A. Morell, M.D., Joseph V. Morrison, Jr., M.D., Gerald B. Muller, M.D., A. D. Muse, Jr., M.D., Joe L. Nettles, M.D., Bruce C. Newsom, M.D., Jeffrey T. Nugent, M.D., James L. O'Quinn, M.D., Clark L. Osteen, M.D., Robert M. Patton, M.D., Garland D. Perdue, Jr., M.D., G. H. Perrow, M.D., John T. Perry, III, M.D., Richard P. J. Pierzchajlo, M.D., Alan Plummer, M.D., Harry Porter, Jr., M.D., Dent W. Purcell, M.D., Keith A. Quarterman, Jr., M.D., William E. Quillian, III, M.D., Corinne F. Quinn, M.D., J. L. Rabb, M.D., Jack A. Raines, M.D., Harold S. Ramos, M.D., Walter J. Ratchford, M.D., William J. Rawls, M.D., Walker L. Ray, M.D., John D. Richmond, M.D., Wells Riley, M.D., Harrison L. Rogers, Jr., M.D., Ronald P. Roper, M.D., Arnold J. Rosen, M.D., Ronald Rosen, M.D., Clyde B. Rountree, M.D., Gerald E. Sanders, M.D., Milton B. Satcher, Jr., M.D., J. K. Schellack, M.D., Eloise B. Sherman, M.D., James M. Skiner, M.D., George L. Smith, M.D., Henry Briggs Smith, M.D., James E. Smith, M.D., Rodney L. Smith, M.D., Tyson D. Smith, Jr., M.D., David S. Sowell, M.D., Ethan F. Staats, M.D., Charles C. Stamey, M.D., Cassius M. Stanley, III, M.D., Richard A. Stappenbeck, M.D., Dan B. Stephens, M.D., Joe C. Stubbs, M.D., O. Wytch Stubbs, Jr., M.D., James H. Sullivan, M.D., Roland S. Summers, M.D., H. Wayne Templeton, M.D., Luther M. Thomas, Jr., M.D., Hugh S. Thompson, Jr., M.D., James H. Tison, M.D., Charles E. Todd, Jr., M.D., Fred A. Trest, M.D., L. Newton Turk, III, M.D., J. R. Turner, M.D., Roy W. Vandiver, M.D., Minor C. Vernon, M.D., Edward Jones Waits, M.D., Lamar H. Waters, M.D., William C. Waters, III, M.D., John D. Watson, Jr., M.D., Alexander H. S. Weaver, M.D., Robert E. Wells, M.D., Richard A. Wherry, M.D., James Q. Whitaker, M.D., William G. Whitaker, III, M.D., Stephen M. Wilks, M.D., William R. Wills, Jr., M.D., Frank L. Wilson, Jr., M.D., J. S. Wilson, M.D., William A. Wolff, M.D., John Thomas Yauger, M.D.

## ALTERNATE DELEGATE ATTENDANCE

William P. Brooks, M.D., Charles C. Burton, M.D., L. T. Crimmins, M.D., Douglas P. Dozier, M.D., David R. Fern, M.D., Margarita Guzman, M.D., Charlie Humphries, Jr., M.D., Dirk E. Huttenbach, M.D., W. K. Lane, M.D., Romulo L. Parungao, M.D., Robert B. Quattlebaum, Jr., M.D., Reuben S. Roberts, Jr., M.D., William C. Tippins, Jr., M.D., Charles J. Ward, M.D., Steve Wilson, M.D.

## APPOINTMENTS OF COMMITTEES

The Speaker announced the appointments of the House of Delegates Reference Committees as follows:

*Reference Committee A* — Philip Z. Israel, *Chairman*, Cobb; E. V. Herrin, *Vice Chairman*, Crawford W. Long; Alan Plummer, Medical Ass'n of Atlanta; Edward H. Smith, Richmond; Roy W. Vandiver, Jr., DeKalb; John Richmond, Whitfield-Murray; Kenneth L. Goldman, Columbus; and Corinne F. Quinn, Gwinnett-Forsyth.

*Reference Committee B* — Edmund M. Molnar, *Chairman*, Muscogee; J. Patrick Evans, *Vice Chairman*, Georgia Medical; William H. Whaley, Medical Ass'n of Atlanta; Charles W. McDowell, Jr., DeKalb; Ronald P. Roper, Cobb; L. E. Brown, Bibb; Wells Riley, Clayton-Fayette; and Floyd E. Davis, Ware.

*Reference Committee C* — J. Dan Bateman, *Chairman*, Dougherty; Teresa E. Clark, *Vice Chairman*, Medical Ass'n. of Atlanta; William Headley, Baldwin; Donald H. Campbell, Cobb; Joseph V. Morrison, Georgia Medical; John Newton, Colquitt; Michael J. Cohen, Richmond; and Alexander H. S. Weaver, Bibb.

*Reference Committee D* — William R. Hardcastle, *Chairman*, DeKalb; Fleming L. Jolley, *Vice Chairman*, Glynn; Garland D. Perdue, Jr., Medical Ass'n. of Atlanta; Leon H. Bush, Richmond; Rodney M. Browne, Bibb; Roland S. Summers, Georgia Medical; Larry Brightwell, Muscogee; and Dan B. Stephens, Cobb.

*Reference Committee F* — Gwynne T. Brunt, *Chairman*, Medical Ass'n. of Atlanta; Luther M. Thomas, Jr., *Vice Chairman*, Richmond; Irving Hellenga, Stephens-Rabun; John I. Dickinson, Floyd-Polk-Chattooga; C. Emory Johnson, Jr., Macon; Robert D. Gongaware, Georgia Medical; Marvyn D. Cohen, Muscogee; Frank F. Middleton, III, Dougherty; Jeffrey T. Nugent, Medical Ass'n. of Atlanta.

*Reference Committee on Constitution & Bylaws* — James Q. Whitaker, *Chairman*, Peachbelt; Ellis B. Keener, *Vice Chairman*, Hall; James O'Quinn, Richmond; Clyde B. Rountree, DeKalb; Walter M. Ligon, Cobb; Alva L. Mayes, Jr., Bibb; Billy D. Burk, Floyd-Polk-Chattooga; and William A. Wolff, Muscogee.

*Credentials Committee* — James H. Sullivan, *Chairman*, Muscogee; and René Morell, Cobb.

*Tellers Committee* — J. K. Schellack, *Chairman*, Medical Ass'n. of Atlanta; James F. Beattie, Jr., Walker-Catoosa-Dade; Chappell A. Collins, Jr., Dougherty; Hugo S. Moreno, Medical Ass'n. of Atlanta; and Dent W. Purcell, Georgia Medical.

*Parliamentarian* — Charles A. Lanford, Bibb.

## ADOPTION OF MINUTES

The Proceedings of the 1986 meeting of the MAG House of Delegates as published in the June, 1986 *Journal of the Medical Association of Georgia*, were approved.

## NOMINATIONS

Speaker Kaufmann called on the House to proceed with nominations for the Officers, AMA Delegates, and AMA Alternate Delegates.

## ELECTION OF UNOPPOSED CANDIDATES

It was agreed at the outset that unopposed candidates would be elected at this Session and the names of the candidates who have opposition would appear on the ballot for election, Saturday, April 25, 1987. Upon nominations duly made and seconded as indicated below, the following slate of unopposed officers were elected by acclamation:

*President-Elect:* Joseph P. Bailey, M.D., Augusta, was nominated for President-Elect by Albert A. Carr, M.D., Augusta, and seconded by James H. Sullivan, M.D., Columbus.

*Second Vice-President:* Richard W. Cohen, M.D., Austell, was nominated for Second Vice-President by Jerry Sanders, M.D., Marietta, and seconded by James H. Sullivan, M.D., Columbus.

*Treasurer:* Cyler D. Garner, M.D., Gordon, was nominated for Treasurer by Bill Holloway, M.D., Macon, and seconded by Alva Mayes, M.D., Macon.

*Secretary:* Ralph A. Tillman, M.D., Lawrenceville, was nominated for Secretary by W. Frank Matthews, M.D., Decatur, and seconded by Hugh Moreno, M.D., Atlanta.

*Elections of AMA Delegates and Alternate Delegates:* Due to the resignation of AMA Alternate Delegate, James H. Sullivan, M.D., Columbus, Dr. Kaufmann ask the consent of the House that the unexpired term of office be included in the election to the full term for the alternate delegate.

*AMA Delegate:* C. Emory Bohler, M.D., Brooklet, was nominated to succeed himself by Harrison Rogers, M.D., Atlanta, and seconded by C. Peter Lampros, M.D., Toccoa.

*AMA Delegate:* Charles D. Hollis, Jr., M.D., Albany, was nominated to succeed himself by Carl V. Hancock, M.D., Albany, and seconded by John P. Heard, M.D., Decatur.

*AMA Delegate:* William W. Moore, Jr., M.D., Atlanta, was nominated to succeed himself by J. Harold Harrison, M.D., Atlanta, and seconded by Gwynne Brunt, M.D., Atlanta.

*AMA Delegate:* F. William Dowda, M.D., Atlanta, was nominated to succeed himself by Gwynne Brunt, M.D., Atlanta, and seconded by E. M. Molnar, M.D., Columbus.

*AMA Alternate Delegate:* L. Newton Turk, III, M.D., Atlanta, was nominated to succeed himself by Gwynne Brunt, M.D., Atlanta, and seconded by James H. Sullivan, M.D., Columbus.

*AMA Alternate Delegate:* Virgle McEver, Jr., M.D., Warner Robins, was nominated to succeed himself by James Whitaker, M.D., Warner Robins, and seconded by E. M. Molnar, M.D., Columbus.

*AMA Alternate Delegate:* C. Peter Lampros, M.D., Toccoa, was nominated to succeed himself by Irving D. Hellenga, M.D., Toccoa, and seconded by Cyler D. Garner, M.D., Gordon.

*AMA Alternate Delegate:* William D. Logan, Jr., M.D., Atlanta, was nominated to succeed himself by Charles R. Underwood, M.D., Marietta, and seconded by Alva Mayes, M.D., Macon.

*AMA Alternate Delegate:* E. M. Molnar, M.D., Columbus, was nominated to fill the unexpired term of James H. Sullivan, M.D., Columbus, who resigned, by James H. Sullivan, M.D., Columbus, and seconded by F. William Dowda, M.D., Atlanta.

*AMA Delegate to the AMA Young Physicians Section:* S. William Clark, III, M.D., Waycross, was nominated by John D. Watson, Jr., M.D., Columbus, and seconded by S. William Clark, Jr., M.D., Waycross.

*AMA Alternate Delegate to the AMA Young Physicians Section:* Joy Maxey, M.D., Atlanta, was nominated by John D. Watson, Jr., M.D., Columbus, and seconded by C. Peter Lampros, M.D., Toccoa.

*Judicial Council:* H. A. Thornton, M.D., Greensboro, was nominated to succeed himself by C. Emory Bohler, M.D., and seconded by John D. Watson, Jr., M.D., Columbus, for a term to expire in 1992.

## DIRECTORS AND ALTERNATE DIRECTORS

Speaker Kaufmann announced the results of the elections for Directors and Alternate Directors as conducted by the District Medical Societies and Component County Medical Societies:

*Eighth District:*
Joe C. Stubbs, Director
S. William Clark, Jr., Alternate Director

*Ninth District:*
Rupert H. Bramblett, Director
C. Peter Lampros, Alternate Director

*WILLIAM D. LOGAN, JR., MAG Past President, and Margaret Watson (Mrs. John D.).*

*Clayton-Fayette County Medical Society:*
Selwyn T. Hartley, Director
F. Peter Nicholson, Alternate Director

*DeKalb County Medical Society:*
Charles McDowell, Jr., Director
Roy W. Vandiver, Alternate Director

*Floyd-Polk-Chattooga County Medical Society:*
Joel Todino, Director
Lambros C. Rigas, Alternate Director

*Medical Association of Atlanta:*
Thomas J. Anderson, Jr., Director
Jeffrey T. Nugent, Alternate Director

*Richmond County Medical Society:*
Luther M. Thomas, Director
Sumner Fishbein, Director
James L. O'Quinn, Alternate Director
Donald C. Abele, Alternate Director.

OFFICERS' REPORTS

President — Not referred.
Immediate Past President — Not referred
First Vice President — Not referred
Secretary — Reference Committee A
Treasurer — Reference Committee F
Speaker — Reference Committee A

REPORTS OF DIRECTORS

All of the following Director's Reports were not referred to a Reference Committee:

First District Medical Society
Second District Medical Society
Third District Medical Society
DeKalb Medical Society
Medical Association of Atlanta
Sixth District Medical Society
Seventh District Medical Society
Eighth District Medical Society
Ninth District Medical Society
Tenth District Medical Society
Bibb County Medical Society
Clayton-Fayette County Medical Society
Cobb County Medical Society
Crawford W. Long Medical Society
Dougherty County Medical Society
Floyd-Polk-Chattooga County Medical Society
Georgia Medical Society
Hall County Medical Society
Muscogee County Medical Society
Richmond County Medical Society

COMMITTEE REPORTS

Access to Medical Care — Not referred
Auxiliary — Not referred
Building & Land — Not referred
Cancer — Reference Committee D
Computers in Medicine — Not referred
Constitution & Bylaws — Not referred
Supplemental Report on Constitution & Bylaws — Reference Committee on Constitution & Bylaws
Continuing Medical Education — Reference Committee D
Cost Awareness — Not referred
Emergency Medical Services — Reference Committee B
Impaired Physicians — Reference Committee F
Legislation — Reference Committee C
Maternal & Infant Health — Not referred
Medical Aspects of Sports — Not referred
Medical Practice — Reference Committee B
Medical Schools — Reference Committee D
Medicine & Human Values — Not referred
Membership — Reference Committee on Constitution & Bylaws
Non-Physician Health Care Providers — Not referred
Occupational Health — Not referred
Physician/Lawyer Liaison — Not referred
Prison Health Care — Not referred
Public Health — Reference Committee A
Public Relations — Rec. 1 — Reference Committee C; Rec. 2 — Reference Committees A & F
Scientific Assembly — Reference Committee D
Specialty Society Relations — Not referred
Third Party Payors — Rec. 1 — Reference Committee C; Rec. 2 — Reference Committee B
Trustee Advisory — Not referred
Ad Hoc on Chiropractic Education — Reference Committee A
Ad Hoc on Composite State Board

of Medical Examiners — Reference Committee A
Ad Hoc on Diversion of Legitimate Prescription Drugs — Not referred
Liaison with Georgia Osteopathic Medical Association — Not referred
Ad Hoc on HMO/IPA Study Committee — Reference Committee B
MAG Liaison with MAG Mutual — Not referred
Ad Hoc on Medical Care for the Disadvantaged — Reference Committee C
Ad Hoc on Primary Care — Reference Committee B
Ad Hoc on PRO Review — Reference Committee B
Ad Hoc on Professional Liability Support Groups — Reference Committee D
Ad Hoc on Radiology Technologists — Not referred
Ad Hoc for Tort Reform — Reference Committee A
Ad Hoc on Young Physicians Section — Reference Committee on Constitution & Bylaws
MAG-GMCF Advisory Committee — Reference Committee A

DEPARTMENTS

*Journal of the Medical Association of Georgia* — Not referred

SPECIAL REPORTS

Auxiliary — Not referred
AMA Delegation — Not referred
MAG Mutual — Not referred
Hospital Medical Staff Section — Reference Committee D
GaMPAC — Not referred
Judicial Council — Not referred
Georgia Health Network — Not referred
Resident Physician Section — Not referred
Student Section — Not referred
Tort Revision Study Committee — Not referred

NEW BUSINESS

The Speaker proceeded to new business by calling for the introduction of Resolutions which were referred to Reference Committees as follows:

RESOLUTIONS

Physician DRGs/RAPS — Reference Committee C
Increase of Cigarette Excise Tax — Reference Committee C
Penalty for Non-payment of Tort Reform Assessment — Reference Committee A
Parental Notification of Teen Abortion — Reference Committee A
Funding of Family Planning Program — Reference Committee B
The Medical Effects of Nuclear War — Reference Committee A
Amendment to MAG Bylaws — Reference Committee on Constitution & Bylaws
Medical Student Participation in the MAG House of Delegates — Reference Committee on Constitution & Bylaws
Tort Reform — Reference Committee C
Alternatives to Tort Reform — Reference Committee C
Teenage Pregnancy — Reference Committee A
Alternative Health Care Delivery Systems — Reference Committee B
Funding for Medical Students — Reference Committee D
Marketing of Georgia Health Network — Reference Committee B
Generic Drugs — Reference Committee C
AIDS — Reference Committee A
Physician Reimbursement in Home Health Care Management — Reference Committee B
Quality Assurance in Home Health Care — Reference Committee B
IPA/HMO (GHN) — Reference Committee B
Patient Rights Under Health Insurance — Reference Committee B
Prejudice Against Some Medical Patients — Reference Committee A
Funding of Catastrophic Medical Care — Reference Committee C
Support of Impaired Physicians Program — Reference Committee F
Generic Drug Substitution — Reference Committee C
Bylaws Amendment — Medical Student Section Voting Delegate — Reference Committee on Constitution & Bylaws
Drug Free Schools — Reference Committee D
Drug Free Schools and Communities Act of 1986/Georgia Implementation — Reference Committee D
Marriage License Medical Certification — Reference Committee A
Fighting Acquired Immunodeficiency Syndrome in Georgia — Reference Committee A
Mandatory Testing for Human Immunodeficiency Virus — Reference Committee A
Definition of Expert Witness — Reference Committee C
Communications to MAG Members — Reference Committee D
For Passage of a Mandatory Seat Belt Law in Georgia — Reference Committee C
Expert Witnesses — Reference Committee C
Position on Profits from Withholding Care — Reference Committee B
Georgia Health Network — Reference Committee B
MAG's IPA and its HMO — Reference Committee B
Legislation — Reference Committee C
Legislation — Reference Committee C
Legislation — Reference Committee C
Job Action — Reference Committee B
Capitation — Reference Committee B
Mandatory Enrollment in HMOs — Reference Committee B
Georgia Health Network — Reference Committee B
Authorization to Evaluate Offers for MAG Headquarters — Reference Committee A

UNREFERRED REPORTS

The reports which did not have any recommendations were not referred to a Reference Committee. All such unreferred reports were filed for information. They are as follows:

## President

**John D. Watson, Jr., M.D.**

This past year has been a very busy one for MAG. With the ever present demand for Tort Reform, a maximum effort was dedicated to this one issue. This involved the participation of many of our Members and Staff and the coordination of the program with the Business Coalition. I am personally very pleased with the progress that we have made, and I am sure the effort will continue.

We were honored to have the Annual Meeting of the Southern Medical Association in Atlanta, which is always a splendid event. Many of your members and officers contributed significantly to make this meeting a smashing success. I cannot overlook the participation of members of the MAG Auxiliary, along with the Auxiliary of SMA, for a superb program as well.

As regards the activities of the Auxiliary of MAG, one cannot say enough. Their year was exemplary and culminated with the launching of a most significant program addressing Teen Pregnancy.

We were able to accomplish the abolishment of the onerous surcharge, which had been placed on many of our members and threatened the basic tenets of patient referral.

Our Leadership Conference was second to none and extremely well attended. Your Staff and Legislative committees addressed over 170 legislative bills presented in the recent session, which had direct effect upon Medicine. Our success rate again was spectacular. The standing committees have made progress in their areas of influence, including addressing the programs of AIDs, development of the Young Physicians Section and a special committee, which has addressed one of the most pressing of all problems facing us — Medical Care for the Disadvantaged. This issue regarding the disadvantaged will be paramount in the legislative arena for the foreseeable future — we must be there in the development.

We have remained within our budget. We have represented you in many States, in the Halls of Congress, under the Gold Dome and before Hearings, Committees and Commissioners. I cannot say enough in gratitude to your Officers, who have shown me every courtesy and support. Nor can I say enough in praise of our Staff — a truly superb Staff. Our Journal, which has been excellent for many years, has taken on a new vibrance with its new Editor and will continue to expand. Our Delegation to the AMA continues to represent your interests at the National Level in the finest manner. Our involvement with the Alliance of State Physician Networks has rekindled much of the lost faith in our ability to defend and represent ourselves in our battle to preserve the "Private Practice of Medicine."

And lastly, our membership has shown that it is willing to become involved in growing numbers, and we must facilitate this involvement and participation. We can accomplish many good things with just Staff and Officers and a few committees. But we could be the catalyst for great things for Medicine and Georgia if we all would "shoulder the wheel."

To say that this year has been a pleasure and a privilege and an honor is a gross understatement. Thank you for allowing me to serve as your President during one of the most challenging years I have seen.

## Immediate Past President

**William D. Logan, Jr., M.D.**

As we all know, medicine as a profession, continues to be challenged and threatened. Your Executive Committee has worked diligently and squarely faced all issues. Our President, John Watson, with staff, led by Mike Fowler, has done a superb job of steering MAG this year.

Tort Reform was carried through and many of our points were taken. Still work must be continued in the future.

MAG Mutual has continued toward a mature company. It has become a beneficial buffer in the insurance field. Under the capable leadership of Charlie Hollis, I am sure it will continue to be such.

The IPA/HMO has made progress but lacks the total commitment of our doctors. Many are still concerned about the HMO but there is no doubt in my mind that participation of our doctors in the IPA is essential if we are going to survive in the economic market. We should continue efforts toward enrolling all our doctors in this effort.

Professional review continues to be a "troubled spot." As a basic tenant, medical professional review should be done by physicians. For years we have attempted this through the physician board of PSRO and now PRO. However, this has created many problems.

This probably is due to the unrealistic rules and regulations set down by HCFA and not from the doctors who work with PRO, per se. They have been coerced and pushed into the present situation by a threat of loss of contract.

I believe the time has come to register our dissatisfaction with the present system. I don't think our doctors want to continue in the "Quisling-like" role. We need to let the powers in Washington know our displeasure and disassociate ourselves with this if necessary.

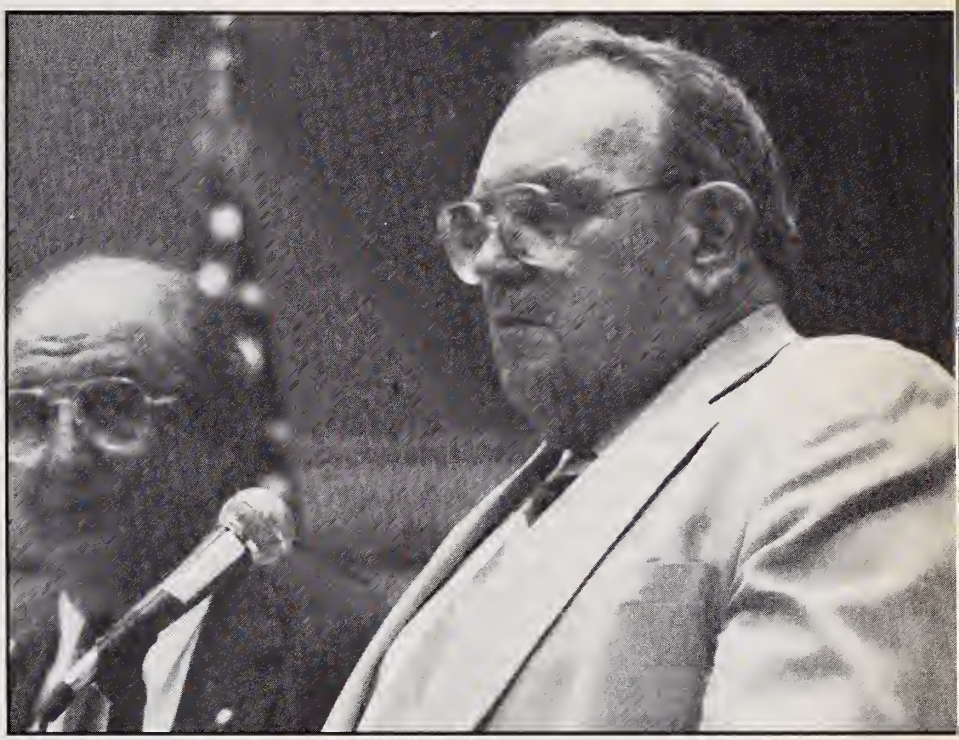
On a more pleasant note, we see that our MAG membership has grown a lot. We certainly represent a strong majority of the physicians in the state and this helps in many ways. As one of the strongest state associations' we gain national recognition and influence. Each of us should personally take this back home and try to further increase our membership.

I should like to take this opportunity again to thank each of you and the MAG staff for your wonderful support over the past nine years as I served as your secretary and president. It was a most eventful time and I enjoyed it immensely. I shall always love MAG, and will support it faithfully.

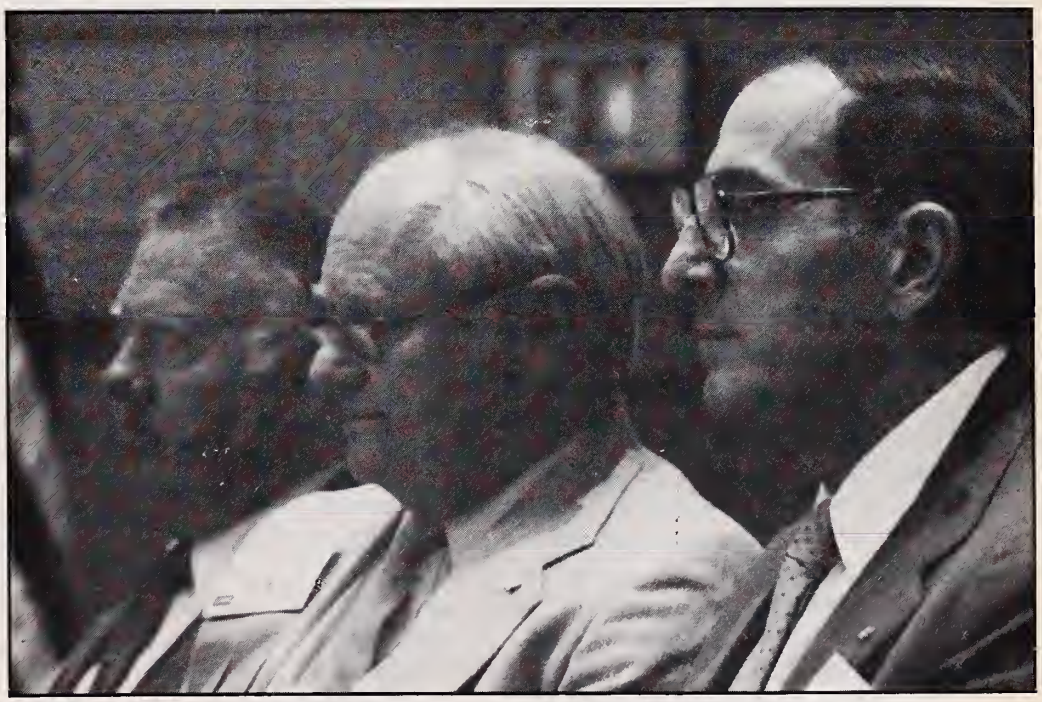
## First Vice President

**Charles R. Underwood, M.D.**

This report to the 1987 gathering of the House of Delegates of the M.A.G. will terminate the present involvement of your First Vice President with the elected leadership of this organization. These past two years during which I have served as your second and then your first vice president — and those many previous years when I sat on the Board of Directors as the representative from the Cobb County Medical Society — have been times of interesting and happy involvement with the affairs of this Association. I leave those responsibilities with something akin to sadness and yet with a certain amount of anticipation that opportunities for continued involvement with organized medicine will present themselves. My only regret is that perhaps I have stayed too long in those positions, thus negating the possibility of younger individuals moving into a position of more active involvement with us. It is a thought not to belittle for as surely as do we for too long a time occupy one of the limited positions of leadership in the Association so do we discourage those younger individuals who must carry this work on in the future. This is not to say that life-long involvement with a worthy cause is to be discredited but only to suggest that if we move ourselves around a bit that then the opportunity for the infusion of new blood — new enthusiasm — viable suggestions for different directions of action become available to us from individuals otherwise kept without our circle of leadership. There is no dirth of capable and



*(L to R) Speaker of the House James A. Kaufmann and Vice Speaker Jack A. Raines.*



*CURRENT, PAST, AND FUTURE Presidents of the MAG: (L to R) John D. Watson, Jr., William D. Logan, Jr., and Jack F. Menendez, respectively.*

interested young physicians awaiting the opportunity to fill the void created by such rotational activities by those of us still interested in participating in the activities of the M.A.G.

I leave this position to Joe Nettles, long active in a variety of responsible positions for the Association — capable and informed and surely to provide steady and enthusiastic leadership. The comfortable and secure feeling one derives from being associated with people such as Dub Logan and John Watson who have occupied the Presidency over the past two years is a gain and a benefit that I shall carry with me throughout the years ahead. I can do little less than encourage those young physicians not yet actively engaged in the affairs of the M.A.G. to look here for the challenge and the consuming enthusiasm that derives from the cordial and meaningful relationships that await those involved with the affairs of the Medical Association of Georgia in the years ahead.

*CHARLES R. UNDERWOOD, a general surgeon from Marietta, was officially installed at this 133rd Session of the House as the new editor of the* Journal of the MAG, *following Edgar Woody's tenure of 32 years as editor. Dr. Underwood had served as Interim Editor for several months and brings much valuable experience and sensitivity to editorial excellence to the* Journal.

## *Journal of the Medical Association of Georgia*

**Charles R. Underwood, M.D.**
**Interim Editor**

### The Year In Review

The year of 1986-87 was an eventful one for the *Journal of the MAG.* Our long time editor, Edgar Woody, M.D., retired from that position and was named "Editor Emeritus." The Executive Committee of the MAG serving as the Editorial Committee, named me as "Interim Editor." Edgar Woody had served the MAG as Editor of the *Journal* for 32 years and was exceeded in longevity in such a position by only one other state journal editor in the country. He left us with a *Journal* of outstanding quality, recognized across the country as one of the better state medical journals. Ed Woody continues in an active advisory capacity to the *Journal* and hopefully will continue to do so for the foreseeable future. During the course of this transition, it seemed wise to retire the longstanding Contributing Editors and replace them with a new, nine member Editorial Board. These individuals are now comfortably in place and functioning effectively. They represent a multidisciplinary group coming from large and small towns as well as from private practice and centers of academia. Our Managing Editor, Ms. Susan Dillon, continues to provide an admirable amount of sensitive and professional management to the publication and remains a most valuable resource for us. Your *Journal* rests at the present time in comfortable, sure, and interested hands.

### The Purpose

We continue to look at the *Journal of the MAG* as a multifaceted publication. Original scientific articles are published to a greater degree than other material, and yet we continue to exhibit an interest in writing related to socioeconomic, political, legal, and philosophic matters. We ask that articles submitted to the *Journal* be original and not submitted to other publications and that our Editorial Board and other reviewers be allowed the prerogative of revising, rewriting, making suggestive changes, or rejecting the material which is submitted. We view the *Journal* as a communicative instrument serving not only the purpose of bringing to the attention of the membership of the Society as well as subscribers across the country matters of scientific interest but also as a means of communicating Association

business to the membership. "Special issues" pertaining to a subject adjudged particularly important are published at various intervals throughout the year. We prefer to publish original material submitted by members of the MAG but in an effort toward completeness will accept or request contributions from others. The Executive Committee of the MAG has adopted a policy of journalistic independence toward the Editor and his Editorial Board all of whom recognize a position of responsibility in regards to the propriety of the material published. The cover of each issue of the *Journal* is in itself a particular effort at relating to the material contained in that particular issue and is developed with care from both reproductions of functional or artistic objects as well as the utilization of original works of art produced specifically for the *Journal.*

**Pertaining to Finances**

We would like to represent a profitable operation for the Association or at least present ourselves in a break-even position. Rather, through the years, we have tended to be at year end in a slight loss position. The negative cash flow is made up by an allocation from membership dues. Our advertising revenue comes both from national and local advertising. We obtain our national advertising through an organization known as The State Medical Journal Advertising Bureau, Inc. At the present time, we are actively engaged in discussions designed to increase the amount of local advertising revenue. It is our intent to pursue a course of fiscal solvency directed toward careful monitoring of expenditures, coupled with an aggressive pursuit of additional advertising revenue.

**The Future**

Your Editor and the Editorial Board intend to strive toward making our *Journal* an even better publication than it has been in the past. Ed Woody has left us an outstanding state medical journal, recognized among its peers as being one of the better in the country. We would like to keep it that way. We are talking about areas in which it can be made of even more use and interest to the membership. We would like to attract an ever increasing number of high quality scientific articles of relevance and importance to our reading public. We see our mission as one of assisting the physicians in the State of Georgia in continuing to provide the highest quality of health care to the people of this State, of having available a line of communication to their State Medical Association, and of having a resource with which to make the practice of medicine and ever more meaningful pursuit of that elusive goal of self worth toward which we all strive.

## Auxiliary to the Medical Association of Georgia

**Mrs. William C. Tippins, Jr. (Barbara), President**

Theme for 1986-87: "Together we Achieve"

*Organization*

There are thirty-six county auxiliaries including the newly formed Camden-Charlton Auxiliary — Baldwin, Bibb, Carroll-Haralson, Cherokee-Pickens, Clayton-Fayette, Cobb, Colquitt, Crawford W. Long, DeKalb, Dougherty, Floyd-Polk-Chattooga, Franklin, Georgia Medical, Glynn, Gordon, Hall, Hart, Jackson-Banks, Laurens, Medical Association of Atlanta, Muscogee, Newton-Rockdale, Ogeechee River, Peachbelt, Randolph-Stewart-Terrell, Richmond, South Georgia, Sumter, Thomas Area, Tift, Troup, Walker-Catoosa-Dade, Walton, Ware, Wayne, Whitfield-Murray.

*Directed by MAG Committee on Auxiliary*

William C. Tippins, Jr., M.D., Chairman; Roy Vandiver, M.D.; Charles Lanford, M.D.; Alva Mayes, Jr., M.D.; Maurice Patton, M.D.; David Thibodeaux, M.D.; John D. Watson, Jr., M.D.

*MAG Committees*

Fourteen (14) Auxilians sit on MAG Committees.

*Membership*

To date: February 24, 1987 — 2263 members.

*Auxiliary Executive Board*

The Executive Board of the Auxiliary to the MAG is composed of twelve elected and appointed officers; all State Presidents; all standing and special committee chairmen and members; all county presidents.

*Meetings and Organizations*

AMA Auxiliary Annual Convention in Chicago in June, 1986 (nine delegates attended); AMA Auxiliary Leadership Confluence I in October 1986 in Chicago (six county presidents elect, the state President-Elect and the state President attended) and the Leadership Confluence II in February, 1987 in Chicago (five county presidents elect, the nominated state president-elect, the state president-elect and the state president attended).

Southern Medical Association Auxiliary Annual Convention in November in Atlanta (A-MAG served as hostesses, the State President delivered the Welcome at the Opening Session Breakfast).

Medical Association of Georgia Leadership Conference in Atlanta, January 31-February 1, 1987 (state president introduced Dr. Sara Charles, a nationally recognized authority on Malpractice Stress Syndrome).

*State Meetings*

*Post Convention Executive Board Meeting,* Callaway Gardens, April 26, 1986. Speakers: John D. Watson, Jr., President of the Medical Association of Georgia; Mrs. Myley Durham (Pat), President Elect AMA Auxiliary; Mrs. Frank Morgan (Margaret

Ann), President SMA Auxiliary; Edward J. Waits, M.D., Impaired Physicians Program; Mr. Morton Harris, Atty., Health Improvement Program (HIP); Dirk Huttenbach, M.D., Adolescent Screening for Drugs.

*Summer Executive Board Meeting,* Atlanta, November 17-18, 1986. *Speakers:* John Richards, M.D., National President DOC, Non Use of Tobacco Products; Pat Harwell, R.N., M.N., "Families, Hostage of Their Own Situations"; Mrs. Shelia Davis (Perry), National Director of the Southern Region, AMA Auxiliary, "Medical Societies/Auxiliaries Working Together As A Team"; and a Membership Workshop; John D. Watson, Jr., M.D., President of the MAG, "Tort Reform"; Rendel Stalvey, Curriculum Director of Health Studies in Georgia Public Schools, "Preventive Health"; Sherry Marsh, Bo Shurling, "You Can Say No" television Public Service Announcements and the Kits.

*Annual Convention of the House of Delegates,* Atlanta, April 24-25, 1987. *Speakers:* Mrs. Jean Hill (Edward), AMA Auxiliary Southern Region Vice President, Mrs. John Hopper (Virginia), President Southern Medical Association Auxiliary, John D. Watson, Jr., M.D., President MAG, and State Representative Johnny Isakson.

*County Meetings*

County auxiliaries meet monthly or every other month. The state president visited the following Auxiliaries: Baldwin, Bibb, Carroll-Haralson, Cobb, Crawford W. Long, DeKalb, Dougherty, Floyd-Polk-Chattooga, Georgia Medical, Glynn, Laurens, Medical Association of Atlanta, Muscogee, Newton-Rockdale, Ogeechee River, Peachbelt, Richmond, Sumter, Thomas Area, Tift, Walker-Catoosa-Dade, Troup, Walton, Ware, Wayne, Whitfield-Murray.

The president addressed the Auxiliaries on Tort Reform; Malpractice Support Groups; "You Can Say No"; Non Use of Tobacco; "Auxilians Helping Auxilians" — Spouses of Impaired Physicians; Membership; Doctors' Day; Adolescent Urine Drug Screen; William R. Dancy, M.D., Student Loan Fund — Sale of the book "History of Medicine in Georgia 1733-1983" by Evelyn Gay; AMA-ERF, Organization of a new county.

The president elect traveled to county auxiliary meetings with the president.

The Legislative Chairman traveled over the state speaking to county auxiliaries on Tort Reform and other legislative issues.

*Publications*

*Pulseline* — Four issues were mailed to all Auxiliary members.

*Pulsations Newsletter* — three issues were mailed to each member.

*Auxiliary Directories* — copies were mailed to each member.

*Annual Report* — copies were mailed to all Executive Board members.

*Auxiliary Issue of the Journal of the MAG* — copies were mailed to all the members of the Auxiliary Executive Board in addition to the members of MAG.

*Projects and Programs*

*State*

*Teenagers, "You Can Say No," Don't Be Pressured Into Having Sex Campaign* — A two year program designed by MAG Public Relations Committee and the Auxiliary. There are two phases: Phase one — Education of the public to the Teenage Pregnancy Epidemic (Georgia ranks fifth in the nation in the number of teenage pregnancies) through television Public Service Announcements, newspaper and radio releases, a Press Conference Media Kick Off Day held at the Academy of Medicine in Atlanta. Speakers for the Press Conference were: John D. Watson, Jr., M.D., President of the Medical Association of Georgia; Marion Howard, Ph.D., Emory and Grady Teen Services; Mrs. William C. Tippins, Jr., President of the Auxiliary to the MAG; and the Keynote Speaker, Mrs. Elizabeth Harris, wife of Governor Joe Frank Harris. Phase two will teach the Postponing Sexual Involvement Program developed by Dr. Marion Howard in the public and private schools.

A Coalition of other interested associations and organizations is being formed to promote the "You Can Say No" program in an effort to reduce teenage pregnancy, sexually transmitted diseases and other undesired effects of teenagers becoming sexually involved before they are mature enough to handle the responsibility of their own actions.

*Spouses of Impaired Physicians* — Designed and printed brochure "Auxilians Helping Auxilians," copies were mailed to all members. Doctors Doug Talbott and Jim Anthony spoke at the Summer Executive Board meeting and distributed laminated billfold cards developed to assist Auxilians to recognizing the signs of disease of alcoholism and the appropriate actions are given for getting the help needed. Pat Harwell, R.N., M.N., spoke at the Winter Executive Board Meeting on "Families of Impaired Physicians, Captive of Their Own Situations."

*Learning Center* — Phase IV, Cardiovascular materials were added to the existing center. A new catalogue was compiled and distributed to county auxiliary presidents. Copies of the catalogue were mailed to Health Curriculum Educators in the Georgia schools. The Learning Center was displayed at a Health Curriculum Educators and Coaches Meeting held at the Falcon Inn in Suwanee. Mr. Rendel Stalvey, Curriculum Director of Health Studies in Georgia Schools, spoke at the Winter Executive Board meeting.

*Child Abuse Prevention* — The puppet show "Someone to Talk To" was presented in elementary schools as part of the "It's OK to Tell" Project, coloring books and posters were distributed in schools. A report on the "It's OK To Tell" Project was given at the National Convention of the Auxiliary to AMA in June 1986 by the auxiliary president, Mrs. William C. Tippins, Jr.,

assisted by the President Elect, Mrs. Roy Vandiver. Work Kits, coloring books and posters were distributed to all national attendees.

*Teen Suicide Prevention* — Information and materials were mailed to all county presidents.

*Substance Abuse* — Distribution of book covers continued in the elementary schools, programs promoting Non Tobacco Use were presented in the schools; educational materials and visual aids on the Hazards of Smoking and the use of Oral Tobaccos were purchased and added to the Substance Abuse Library. A puppet show on the Non Use of Tobacco Products was developed by a county auxiliary for use in elementary schools. "Drugs are a Drag" Puppet Show continued to be utilized in some schools.

Medical Society/Auxiliary Projects — Working together as a team has been emphasized all year in many areas (Legislation, Membership, Health Projects, Fund Raisers, etc.) Several projects requiring the participation of both organizations were developed: *Adolescent Urine Drug Screen* — physicians and hospitals conduct the actual screening; auxilians help in publicizing the service; *Malpractice Support Groups* — Malpractice Support Group Formats were designed for use in the county society/auxiliary. MAG/AMAG Committee on Malpractice Support developed two brochures on "How to Form a Malpractice Support Group" and "Tips on How to Support." These were mailed to all medical society/auxiliary members in Georgia. A series of articles on Malpractice were published in the *Journal of MAG.* Sara Charles, M.D., a psychiatrist and national authority on Malpractice Syndrome, was procured to address the MAG Leadership Conference in Atlanta in January.

*Nutrition Survey* — MAG and the DHR conducted the second survey utilizing Auxiliary members. This program is a computerized survey of high school students in a designated area of the state. The questions were to determine health risks and they dealt with smoking, exercise, auto safety, diet, alcohol and other drugs, sexual activities, and stress. Computer printouts were given to the students so they could determine their own health risks and get assistance in the problem areas.

*Older Americans* — Distribution of some medi-cards continued; the Auxiliary began a service for its own members by appointing a committee to produce a booklet on "The Surviving Spouse — How to Cope" which will include such topics as Settling an Estate, a Necessary Documents list and locator, Selling the Physician's Practice, Tax Information, Legal Information as pertaining to Georgia, Liability Insurance, Real Estate, etc. The committee hopes to have the booklet ready early in the Fall.

*Membership* — Developed an information brochure "Did You Know" a list of the programs and activities of the Auxiliary. A membership invitation to join the Auxiliary was revised and reprinted.

*Legislation*

*Key Contact Program* — continued the matching of auxilians with the names of the legislators for the purpose of communicating medicine's views on the legislative issues such as Tort Reform.

*Spouses Involvement Program* — Established the SIP (patterned after the PIP) to encourage county auxiliaries to select specified days to come visit their legislators in the Capitol, to talk over medically related pending bills and to take their legislators to lunch whenever possible.

*Legislative Phone Bank* — for the first time phones were established at the MAG Headquarters and manned by auxilians from the surrounding area for the purpose of contacting physicians in designated areas to request that they contact their legislators concerning specific issues and pending bills.

*Voter Registration* — Auxilians set up voter registration tables in strategic locales to aid in the registration of hospital workers, nurses, medical students, interns, others.

*GAMPAC — AMPAC* — Auxilians were encouraged to have family memberships in GAMPAC and to contribute to AMPAC, as well. Auxiliary members from each Congressional District were recommended for membership on the GAMPAC Board.

*Programs and Project Bank* — Two State Projects, "You Can Say No" and "Auxilians Helping Auxilians" were submitted to the National Project Bank housed in Chicago. Auxiliaries were encouraged to utilize the National Project Bank, as well as contribute all county projects which were submitted for Awards at the Annual AMAG Convention, to the State Idea Bank.

*Doctors' Day — March 30* — Auxiliaries were encouraged to have Community Service Projects to honor the physicians, as well as social events and activities.

*County Projects and Programs*

County auxiliaries conduct their own projects as determined by their local needs; projects, therefore, are naturally varied. County Auxiliaries also participate in state projects which in truth require the county auxiliaries for implementation, they are the grass roots of the Auxiliary pyramid — county, state and national Auxiliary. They volunteer their time, talents and expertise to promote a better, healthier society.

Programs conducted by the county auxiliaries include: Alcohol and Drug Abuse, Teenage Suicide, Teen Pregnancy, Child Abuse Prevention, Seatbelt Safety, Infant Car Seat Restraint Projects, Hazards of Smoking and Use of Oral Tobacco; Health Improvement Program (HIP), the Learning Center, Nursing Scholarships, Screenings for Vision, Hearing, Dental, Blood Pressure, Scoliosis, Self Breast Examination, Seminars on Osteoporosis, Health Fairs, Battered Women and Children Shelters, GEMS, (Good Emergency Mother Substitutes) Meals on Wheels, Eyeglasses for the Less Fortunate, purchased equipment and donated to hospitals, and the

list goes on.

County auxiliaries worked in coalition with other organizations to produce seminars on Drug Abuse, Child Abuse, Teen Pregnancy, Osteoporosis and other health related issues.

The Auxiliary to the Medical Association of Georgia is very grateful to the members of the MAG Committee on Auxiliary and the MAG Board of Directors for their advice, encouragement and help which they afforded the Auxiliary. The staff of MAG has been extremely helpful in promoting all of the Auxiliary's endeavors. A sincere thank you is extended to each member of the three above named groups.

## AMA Delegation

**C. Emory Bohler, M.D., Chairman**

*Introduction*

The AMA House of Delegates met in Las Vegas, December 7-10, 1986.

There were 392 delegates seated:

313 delegates representing state medical associations

69 delegates representing national medical specialty societies

10 Section and Service delegates representing medical students, medical schools, resident physicians, hospital medical staffs, young physicians, Army, Navy, Air Force, USPHS, and the Veterans Administration.

*Young Physicians Section:*

The inaugural meeting of the Young Physicians Section was held in conjunction with the House of Delegates to discuss issues of special concern to physicians under 40 and out of residence. Forty-six states and Guam were represented.

*Items of Business:*

The delegates considered 95 reports and 143 resolutions which is the largest volume of business submitted at an Interim Meeting. Problems related to PRO regulations dominated the discussion in lengthy debate before the Reference Committee and on the floor of the House. A number of other issues affecting the future of medical practice and medical practice and medical education were on the agenda.

Following are highlights of the Interim Meeting:

*MD — DRG — Medicare Reimbursement*

The government's plan to roll physician reimbursement into Medicare payments to hospitals is being vigorously opposed by the AMA.

The House adopted a resolution that adequate and appropriate resources of the Federation of American medicine be mobilized forthwith to impress upon the President and the Congress the danger this proposal represents and the threat it poses to the American people.

While members of the House began contacting their Congressmen and Senators to express opposition to the proposal, the AMA issued the following statement:

> "The proposal is unrealistic, unreasonable, unwise and unhealthy for our senior citizens and other beneficiaries of the Medicare program. Merely saying that such a system would be almost impossible to administer, or that the proposal is premature, since Congress has already mandated a study of physician payment systems under Medicare, only addresses the fringes of OMB's proposal. The real point of this is that the proposal represents just one more step on the road to rationing of care for Medicare beneficiaries. We simply don't think that's acceptable; and we believe that Medicare beneficiaries will join us in resisting these proposals ultimately aimed at rationing medical care."

*Peer Review Organizations (PRO's)*

The House of Delegates considered a comprehensive report and a number of resolutions on the many problems physicians are having with the federal government's peer review program (PRO): The House adopted the report from the Council on Medical Service which:

1) described current directions in the PRO program and recent legislative mandates having an impact on PRO contained in COBRA and OBRA; and
2) discussed issues raised by the operation of the Super PRO and imposition of sanctions by PRO's, and the authority for PRO's to deny payment on the basis of quality.

The report recommends that:

> the AMA develop draft federal legislation providing that a PRO shall not notify a beneficiary of a PRO determination that the quality of services provided does not meet professionally recognized standards of health care until the physician has:
>
> 1) obtained a PRO reconsideration of the determination;
> 2) exhausted rights to judicial review of any adverse reconsideration decisions.

In adopting the report the delegates stressed the need for immediate action concerning the issue of beneficiary notification of quality denials.

The House also referred a resolution for action calling on the AMA to:

> communicate with the Department of Health and Human Services the AMA's desire to seek greater PRO discretion in the determination and handling of sanction recommendations.
>
> undertake legal action, as appropriate, to assure that physicians are accorded due process appeal rights in the course of PRO sanction and appeal processes.
>
> urge that reconsiderations and appeals of PRO actions be heard before panels of physicians in active practice.

The House adopted another resolution that asked the AMA to:

> enlist the aid of Medicare pa-

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

**WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

**Contraindications**: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings**: **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum $K^+$ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict $K^+$ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

**Precautions**: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

**Adverse Reactions**: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

**Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.**

BRS-DZ:L42

# In Hypertension*... When You Need to Conserve $K^+$

## Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum $K^+$ and BUN should be checked periodically (see Warnings and Precautions).

Potassium-Sparing

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J-6138 January 1986

tients by encouraging them to voice any valid concerns with the PRO program to their elected federal officials.

encourage individual physicians to facilitate such valid patient complaints against the PRO program and forward such complaints to the AMA.

*New AMA Strategic Plan*

In a major effort to strengthen public and professional confidence in the AMA, the delegates adopted a new strategic plan for the Association and four strategies to provide the AMA with an effective approach to meet future challenges.

As adopted by the House, the AMA's new key objective reads:

"The key objective of the American Medical Association is to contribute to the professional and personal development of member physicians and to the betterment of the health of the public by developing and distributing information; by advocating health-related rights, responsibilities, and issues; and by representing the profession as a whole where the image, expertise, and national scope of the AMA prove useful. This is to be done in a manner that is cost-effective, protects physician autonomy and self-determination, improves the practice of medicine, and builds public confidence in the competence and the reliability of physicians."

The four strategies are:

Strategy One:

Strengthen the Association's visibility among the profession and the public while enhancing its reputation for competence, objectivity, and commitment to excellence.

Strategy Two:

Shift the development of Association products and services from a product-driven to a market-driven approach based on an accurate determination of approach based on an accurate determination of physician and public needs as well as a realistic appraisal of the likelihood for a positive return on the Association's investment.

Strategy Three:

Visibly personify the best in medicine by promoting excellence in health care and in all that the Association does and represents.

Strategy Four:

Utilize the Association's key objective as a driving force to redirect and sharpen the focus of activities throughout the organization and to enhance the AMA's management structure and process to facilitate the most effective and efficient implementation of such activities.

*AMA Budget — Fiscal 1987*

The House approved the consolidated budget for fiscal year 1987. The budget includes:

$151,410,000 in operating revenues
$147,190,000 in operating expenses
No dues increase for 1987

*Negotiating by Physicians*

The House considered an in-depth report on the issue of meeting physicians' needs in the area of negotiations. The report:

reviews physicians' need for information and representation in negotiation and contract issues

outlines legal aspects involved

The report identified five major factors contributing to the problems of adolescents:

substance abuse
sexuality/pregnancy
victimization
psychological disorders/suicide
violent crime

The report recognized that a successful initiative will require sustained commitment to produce the desired improvement in adolescent health.

*Guidelines on AIDS*

The House accepted two reports on AIDS that:

provided physicians with guidelines to help them in responding to questions regarding AIDS

opposed acts of categorical discrimination against AIDS patients, HIV positive individuals, and persons at increased risk of developing AIDS.

*Use of Animals in Research*

In a number of actions related to the use of animals in research, the House:

reaffirmed AMA's unequivocal endorsement for the humane care, treatment, and proper stewardship of animals in research

oppose the illegal acts of so-called "animal liberationists"

continue to defend and promote the use of animals in meaningful research, product safety testing, and teaching programs

Commit resources to public educational program

support the policy of obtaining animals for medical research and education from animal control units and study ways to ensure the animals used are indeed unwanted and abandoned.

*Health Policy Agenda for the American People*

The House considered a status report on the massive project to formulate a health policy agenda for the American people. The Board reported that:

HPA's final report is scheduled to be released in early 1987

all HPA participating organizations have been sent a draft copy of proposals

an HPA Implementation Committee has been appointed by the Steering Committee to oversee implementation of HPA policy recommendations

implementation of the HPA will be carried out primarily through the efforts of a number of coalitions that form around individual policy proposals or groups of similar proposals

financing is being solicited for the administrative costs of the implementation effort, including staffing, meetings, publications and mailings.

*Conclusion*

AMA House meetings provide a unique educational opportunity and I would encourage you to attend and participate. Any member of the Association may present testimony at the Reference Committee hearings and, of course, corridor discussions on the issues provide additional opportunities to get your views across.

If you can't come to the meeting, you can still be represented through your delegates. Let your delegation know our opinions. You can also prepare a resolution and request that it be submitted to the House.

Many AMA policies began with an individual physician who had a good idea and coaxed it through the democratic process.

## MAG Mutual Insurance Company

### The Board of Directors MAG Mutual Insurance Company

A physician-owned professional liability insurance company in Georgia was never before so sorely needed, or a more valuable asset, than in 1986. And MAG Mutual was here, thanks to the support of our many policyholders, our founders, the physicians who serve on the Board of Directors, and the Medical Association of Georgia. In 1986, more than ever, MAG Mutual honored its commitment to truly serve Georgia physicians. "We're here for you — you can count on it!" was the pledge we put into action.

MAG Mutual has continued to offer professional liability insurance to qualified new applicants in a market where no other major carrier would — and that statement remains true to this day. This past year your physician Board of Directors modified the Company's Surplus Certificate program to accommodate the many physicians who were turning to us as an answer to the liability insurance dilemma. The new program enabled MAG Mutual to strengthen its financial foundation at the same time we insured additional doctors, in accordance with our policy of conservative management. As a result, in 1986 we insured over 500 new physicians and significantly increased all-important Policyholder Surplus.

| | *Year-End 1985* | *Year-End 1986 (Estimated)* |
|---|---|---|
| Total Number of Insureds | 2,681 | 3,045 |
| Written Premum | $25,000,000 | $38,700,000 |
| Invested Assets | $33,878,000 | $55,000,000 |
| Average Return on Assets | 10.0% | 8.0% |
| Policyholders' Surplus | $ 4,036,888 | $ 6,500,000 |
| Reserves | $28,930,000 | $46,000,000 |
| Total Claims (Since Inception) | 1,374 | 1,853 |
| Open Claims | 704 | 896 |
| Claims Paid | $ 4,125,361 | $10,040,507 |
| Expense Ratio | 7.6% | 6.5% |

*MAG Mutual Is Different*

Once again, your Company was the only medical liability insurance carrier to join the Medical Association of Georgia and others in the aggressive pursuit of legislative relief. MAG Mutual's presence was strongly evident not only at local civic organizations all over the State and throughout the year, but also at meetings of the Governor's Advisory Committee on Tort Reform and at hearings held by various committees of the Legislature during the fall of 1986. The testimony we presented clearly demonstrated, with solid figures, that the escalation in liability insurance premiums was due to losses in the tort arena, and *not* to collusion or mismanagement by the insurance industry. The need for meaningful tort reform exists; the proof that it works is factual. But again, tort reform is not the only solution to the medical liability problem.

Our improvements in benefits during 1986 did not stop there. After thorough deliberation, your Company decided to create a fresh meaning to the term "loss prevention" through the development of an entirely new program, encompassing physicians, medical personnel and the hospital environment as well. Entitled *Good Practice,* this new loss prevention program will include multiple half-day workshops all around the State which carry a premium discount for our policyholders. We will also offer a videotape loan library; a poster series for hospitals; coordination with the Medical Association of Georgia's Committee on Professional Liability Support Groups; a variety of pertinent educational materials, including a new newsletter packed with loss prevention tips; and much more. In the future, our new *Good Practice* program will be expanded to include office consultation.

The high quality and dependability of MAG Mutual's claims service are also borne out by commendable results: in 1986, we opened 472 claims files and closed 399, with loss payments on only 78, less than 20% of these claims. Our record of winning 87% of all cases tried since the inception of the Company is due to that same successful combination that is pervasive throughout the Company: experienced staff members coordinating with physicians from the Board of Directors who also serve

as Committee members — in this instance, our Claims Committee. Additionally, this past year we expanded the Claims Department to better handle the growing number of policyholders and resultant claims, in keeping with our commitment to provide the most thorough and reliable claims service in Georgia. In short, we have made certain that our policyholders know they can count on us to defend groundless suits to the end, yet seek to equitably settle those cases which have merit.

This past year, more than ever, physicians across the State have depended on MAG Mutual to honor our pledge to be "here for you," in the good times as well as the bad. We have honored that trust to the best of our ability. Equally important, your Company has consistently increased the value of our services through innovative underwriting, exceptional claims management, pursuit of legislative relief, and our pioneering efforts in loss prevention. With your support, MAG Mutual will continue to improve existing programs and to seek out additional ways to serve you and that is a commitment you can count on.

*The Board of Directors of MAG Mutual Insurance Company*

William H. Biggers, M.D.; Carson B. Burgstiner, M.D.; William C. Collins, M.D.; Daniel D. Hankey, M.D.; Ralph L. Haynes, M.D.; John P. Heard, M.D.; Charles D. Hollis, Jr., M.D.; Philip Z. Israel, M.D.; John W. Kelley, M.D.; William D. Logan, Jr., M.D.; Alva L. Mayes, M.D.; James C. Morgan, III, M.D.; Bruce C. Newson, M.D.; Jack A. Raines, M.D.; Walter J. Ratchford, M.D.; Carl A. Smith, M.D.; H. Briggs Smith, M.D.; David A. Wells, M.D.; Joseph S. Wilson, M.D.

## GaMPAC

**Beverly B. Sanders, M.D.**

The 1986 MAG House of Delegates requested GaMPAC to increase its dues to $250. GaMPAC did and our membership actually grew 2%; a total of 26% of MAG members. This obviously permitted GaMPAC to contribute more money to more candidates than in the past.

We cannot help but think GaMPAC's participation in the political process is a vital link in the MAG chain that produces the positive legislative results achieved during the 1987 Georgia General Assembly.

Georgia now has the only M.D. who is elected to Congress, J. Roy Rowland, Dublin. We also have one M.D., George Green, Sparta, who is now serving his first term in the Georgia House of Representatives.

There is a greater need for the GaMPAC Board of Directors and the GaMPAC Executive Committee to be more active than in the past. We need to constantly increase our membership — increase our visibility at every county medical society meeting — specialty society meeting and hospital medical staff meeting. The individual members of the GaMPAC Board will be requested to make presentations at any and all meetings possible where new members can be solicited.

The MAG Auxiliary has been very beneficial in soliciting GaMPAC membership and therefore our new dues structure will make all auxiliary members, members of AMPAC as well as GaMPAC.

The GaMPAC Board voted to create a membership category for medical students and residents and we will actively begin soliciting these potential members this year.

The GaMPAC Board, in its quest to improve GaMPAC, is seeking some new blood as members to the GaMPAC Board and will be contacting county medical societies and leaders in the medical communities asking for recommendations of names for consideration to serve on the GaMPAC Board.

As a part of this annual report are the minutes of the last February 1, 1987 GaMPAC Board meeting to illustrate to the MAG the direction the GaMPAC Board wishes to move.

## Judicial Council

**C. Emory Bohler, M.D., Chairman**

MAG's Judicial Council did not formally meet during the 1986-87 term, however, the Judicial Council carried out its mandated duties through administrative actions. Numerous requests for membership status changes were presented and handled by correspondence with each Council member without the necessity of a formal meeting. No appeals nor any other new matters were presented for action. Most complaints were handled administratively through MAG's Office of General Counsel or by the appropriate county medical society.

There was one carry over matter from the prior Council's term concerning an allegation of unethical physician billing. An investigative jury was impaneled and gathered information relevant to the charge which had been denied by the physician. Considerable effort in preparing the proceedings were expended by legal counsel for the physician and MAG. The issue was rendered moot when the physician did not renew membership in MAG.

## Georgia Health Network

**S. William Clark, Jr., M.D.**

Georgia Health Network is the first medical society sponsored, statewide IPA in the country. To date four other state medical societies have replicated our experiment, and some 20 more are in varying stages of study and development.

In many respects, the shorthand "IPA/HMO" does a great disservice to the thoughtfully crafted structure of our MAG venture. Unfortunately, some of our own MAG members think of GHN as "just another alternative delivery system," or worse yet "just another HMO."

Georgia Health Network is our own, stand-alone IPA whose mission is indisputably pro-physician.

GHN deals from a totally physician oriented standpoint with all players in the volatile arena of medical finance.

The IPA Steering Committee that worked so diligently to bring GHN into being operated with several philosophical points in mind.

First, the IPA venture would always be a MAG-controlled, pro-physician entity. Thus, MAG holds total voting control of both the IPA, and its companion entity, the HMO. And the IPA President reports regularly to the MAG Board of Directors, just as do the presidents of other MAG-sponsored ventures.

Second, the mission of the IPA would be to serve the best interests of its member physicians in dealings with third party payors, *including* our own, captive HMO. We would not agree to "across the board" fee discounts, and we would fight against "gatekeeper" and "capitation" reimbursement arrangements.

And finally, our IPA had to be structured within the constraints of federal antitrust laws. To do so, it was necessary that we "pool capital" and "share risks."

Clearly, GHN is not "just another HMO." A major thrust of our efforts has been toward PPO arrangements. We are working toward the creation of PPO relationships with a number of employee and union groups. But more importantly, we are moving toward relationships with major indemnity insurance carriers who recognize that GHN — and only GHN — can provide the PPO and HMO legs of the so-called "triple option" statewide.

In all these negotiations, we have argued in favor of reasonable fee ceilings, coupled with physician incentives for cost control that do not impact the quality of patient care. To the extent we have been successful in changing the way these major insurance players perceive the issue of physician reimbursement, we have accomplished a major objective of our venture — to represent the interests of the physician community in shaping the emerging medical marketplace.

When the Department of Defense announced plans in 1986 to contract out the CHAMPUS program to large insurance companies on a "fixed fee" (i.e., capitated) basis, with potentially disastrous impact upon Georgia physicians, we immediately established and have maintained contact with William Mayer, M.D., Assistant Secretary of Defense for Health Affairs, and Congressman J. Roy Rowland, M.D., of Dublin on the subject.

When DoD picked Georgia as one of the test sites for its pilot study, one of the reasons given was the presence of our physician-driven, statewide delivery capability, which is unique in the country.

The future of CHAMPUS reform is far from clear. But if it proceeds as planned, physicians must be represented at the table *before* the contracts are let, and the *only* entity that can legally represent physicians statewide in Georgia is GHN.

Apart from these broad based IPA activities, GHN has its own, captive HMO.

Our insurance license was issued in February 1986, and we sold our first account in May, with coverage effective in July. There are now some 1,600 covered lives under the plan. While this is a respectable showing, it is certainly less than our expectations and we have moved on several fronts to bolster our marketing program; we have employed a new Marketing Director who has substantial experience, we have redesigned our benefit plans to be more cost-competitive with traditional indemnity insurance, and we have developed a network of brokers to market our product on the broadest possible geographical scale.

Within our covered populations, our financial projections have been on target, and 100 percent of the "risk pool" funds withheld during 1986 was refunded to our member physicians. Our annual certified audit was issued without qualification and GHN ended the year with an operating loss of $504,036 and total stockholder equity of $1,192,964.

Long term, there is one marketing issue that is directly controlled by physicians and that will determine the success or failure of our HMO (and perhaps our IPA). Can physicians own and operate a managed care plan that is truly "market driven," as it must be in order to succeed? We have, after all, repudiated some of the cost control measures that others consider central to the success of any HMO, such as gatekeepers, discounts, and capitation. Can we discipline ourselves to control costs when it directly affects our own financial position?

Our early experience with physicians not accustomed to dealing with HMO's suggests that a great part of our task will be to convince Georgia physicians that only by acting together — through the MAG IPA — can we maintain our stability in today's heavy seas of medical economics. "Managed care" is not something we can wish away, but a "managed response" to the volatile situation in which we all practice is possible through our statewide IPA of MAG physicians.

## Resident Physician Section

**Regina Benjamin, M.D., Chairperson**

Now in its third year of existence, the Medical Association of Georgia Resident Physician Section continues to demonstrate resident involvement at both the state and national levels of organized medicine.

Last year the House of Delegates directed the Membership Committee to "develop a mechanism to expedite resident physician membership in MAG." As a result of our efforts, resident membership in MAG stands (as of March 17) at 396. Ninety-one per cent of these are clustered near the state's largest medical training centers:

| | |
|---|---|
| Medical Association of Atlanta | 197 |
| DeKalb Medical Society | 47 |
| Richmond County Medical Society | 43 |
| Bibb County Medical Society | 40 |
| Muscogee County Medical Society | 36 |

We express our continued appreciation to MAG Mutual Insurance Company for agreeing once again this year to cover payment of a resident's first year membership dues, both at the county and MAG level. MAG dues for resident members remain $15. County dues are as follows:

| | |
|---|---|
| Bibb | $25 |
| DeKalb | 25 |
| MAA | 25 |
| Ga. Medical Society | 15 |
| Muscogee CMS | 15 |
| Floyd-Polk-Chattooga | 10 |

Richmond CMS — $30 application fee; $10 meal charge per attended meeting

Throughout the year Georgia's residents have participated in AMA House meetings. Last June in Chicago our Section was represented by myself, Dr. K Kramer, Dr. Joy Maxey, Dr. Steve Wilson and Dr. David Brown. We reported on our activities at the meeting in an article for the *Journal of the Medical Association of Georgia* (September 1986). And at the Interim Meeting in Las Vegas last December, there were six residents; myself, Dr. Kathy Easterling, Drs. Kramer, Brown, Maxey and Wilson.

A highlight of the past year was the election of Dr. Karolyn Kramer, second year anesthesiology resident at MCG, as Resident Member of the AMA Council on Scientific Affairs. K is running for re-election at the AMA House this June. Our Section wishes her continued success.

I would like to thank my colleagues on the MAG RPS Governing Council, Drs. Easterling, Wilson, Maxey and Kramer, and in doing so stress our commitment to continue efforts to involve Georgia residents in the activities of MAG.

*MEDICAL STUDENTS Carlton Clinkscales (L) and James McGhee (R) took time off from their studies at Emory University School of Medicine to attend this year's House meeting. Donna Glass, Secretary to MAG's Department of Education, helped set up the meeting of the Medical Students Section.*

## Medical Student Section

**James McGhee, Chairperson**

This is our third year of operation as a formally constituted section of the Medical Association of Georgia. We continue to grow.

*Membership*

Thanks to a particularly robust membership campaign last fall at Emory, our student membership presently stands at 178. We are not as strong as we would like to be, but as in past years we have found that the key to recruitment is having one or two *very energetic* MSS leaders, eager to spread word about the AMA among fellow students.

*Newsletter*

We are also proud of the new format of our MSS Newsletter *Murmurs*. Under the capable editorship of David Greenhouse, of Emory, this year *Murmurs* has become an effective means of communication among students at our four campuses, and also of recruitment, as we try to distribute our Newsletter to all students at MCG, Morehouse, Mercer and Emory.

*MAG Committees*

This year we have made an effort to involve medical students in MAG Committees, so we can learn about MAG activities and contribute to them. Current student memberships on these various committees is as follows:

Henry Anderson, Morehouse
Maternal & Infant Health Care Committee
Chris Larsen, Emory
Access to Medical Care Committee
Steve Dawkins, Morehouse
Legislative Committee
James McGhee, Emory
Medical Schools Committee

*AMA Meetings*

Our local points of activity each year remain the AMA Medical Student Section meetings, held during the several days before the Annual and Interim AMA House of Delegates meetings. Thanks to a MAG grant of $685 per school, and to additional funds contributed by the administration of each school, Georgia has been represented by sizable delegations to the AMA MSS:

June 1986, Chicago — Georgia students attending:

Kathleen Nixon — Emory
Chris Larsen — Emory
James McGhee — Emory
Mary Ann Schlosser — MCG
Stacie Wong — MCG
Bobby Campbell — Mercer
Earl Mullis — Mercer
Hal Bivins — Mercer
Mironda Williams — Morehouse
Steve Dawkins — Morehouse

December 1986, Las Vegas — Georgia students attending:

Chris Larsen — Emory
Louis McLiu — Emory
Mary Ann Schlosser — MCG
Stacie L. Wong — MCG
Bonnie Brinson — Mercer
Bobby Campbell — Mercer
Mironda Williams — Morehouse
Angelique Devold-Amos — Morehouse

*Students' Liability Insurance*

On behalf of the entire Medical Student Section, I would like to express my appreciation to the Medical Association of Georgia's Executive Committee, Council on Legislation and the staff for their success in winning passage in the past Georgia General Assembly of a bill that relieved students of professional liability risks. Last year, medical students at the Medical College of Georgia faced an enormous increase on their premiums for liability insurance; the recently enacted statute provides immunity from lawsuit to Georgia's medical students, and hence relieves our students from having to meet these onerous insurance costs.

Finally, I'd like to commend heartily my fellow officers on the MAG MSS Executive Council. Throughout the year, especially on their respective campuses, they have worked hard at recruitment and other activities. They are:

Stacie L. Wong, Augusta — MCG
Steve Dawkins, Atlanta — Morehouse
Kathleen Nixon, Atlanta — Emory
Cam Pridgen, Macon — Mercer
Mironda Williams, Atlanta — Morehouse
Earl Mullis, Macon — Mercer

## Tort Revision Study Committee

**John D. Watson, Jr., M.D., Chairman**

This was one of the busiest and most involved committees of the Association. I wish to thank all of the members and staff for their dedication, perseverance and energetic application to this activity.

The development of the marketing and public relations campaign. The many speaking and complaining engagements throughout the state for both members of the Profession and the lay public. The seemingly endless meetings every Thursday with members of the State Bar and the Trial Bar and additionally the Governor's Task Force on Tort Reform throughout the Summer and most of the Fall. The collaboration with the Business Coalition and our insurors.

The effort put forth was monumental and a continual trial of patience, sanity and strategy. I cannot say enough to properly commend and thank the participants. You were indeed well served, and, although the final proposal did not contain all that we would desire, I am convinced that we have made significant progress in a desperate conflict that will never be won in a single battle.

The Art of Politics still remains what is obtainable. We willl be there until we succeed in a fair and equitable adjudication. We have only begun, and this committee and others to follow it will need to reconcile themselves to the persistent dedication and application that will be necessary for us to hold and improve our position. It will not be easy; it will continue to be a constant battle. If we are not prepared to persevere, we are lost at the beginning. We can succeed. We must succeed.

## Access to Medical Care Committee

**M. Julian Duttera, Jr., M.D.**

During the past year the Access to Medical Care Committee has considered the following activities relating to recruitment and retention of physicians in Georgia:

For the past several years, the State Board of Medical Education has served as the principal coordinator of the Medical Fair. Its scope is limited legislatively to placement of its scholarship registrants in communities of 15,000 or less. The question again arose as to whether the Board of Medical Education could use other parameters of need than the 15,000 population. The consensus was that it would probably take legislative change and that unless the Board of Medical Education indicates an interest in making such change, it would not be politically feasible to recommend further action at this time.

Statistical information furnished by the State Medical Education Board of Georgia indicates that 120 physicians who have attended or received information on communities at the 1979-1985 Medical Fairs are now practicing in communities in Georgia of 15,000 population or less or under the auspices of the Georgia Department of Human Resources. Of this 120, only seven are no longer practicing in the community.

*Physician Placement Expo 87* (1986 House of Delegates)

The MAG and other sponsors of the Medical Fair felt the need to expand activities to include other opportunities and to provide more assistance to other specialties. For this reason, the Access to Medical Care Committee recommended, and the 1986 MAG House of Delegates approved, the development of a statewide job fair (Physician Placement Expo 87) with specific parameters. These parameters, in part, specified that the primary emphasis would be directed toward involvement of specialty societies and toward those areas not included in the Medical Fair. In addition, the Georgia Hospital Association, the Joint Board of Family Practice and other sponors of the Medical Fair would be asked to cosponsor the program.

The MAG Interspecialty Council expressed a reluctance to be involved in this type program. Subsequent telephone conversations with the current Presidents of all the

specialty societies in Georgia revealed that: 1) with only one exception the specialties as a group are not recruiting new physicians; 2) even if they were interested, they would not want to participate in a job fair setting; they prefer to be more selective; 3) each specialty society provides some assistance upon request and would be interested in receiving CVs of physicians within their specialty, who are seeking practice opportunities in Georgia, for distribution in response to these individual requests.

Staff representatives of the involved agencies met to discuss the ongoing efforts of each organization and how these could be incorporated into the planning of the Expo. Although each organization provides assistance on a case-by-case basis, only the Joint Board of Family Practice has full-time staff devoted to placement.

Although the Joint Board of Family Practice was established in 1976 to establish and monitor family practice residency programs, it now allocates funds to support all specialty programs.

The Board provides assistance to communities in need of physicians, physicians who desire to expand, relocate, or close their practices, and to residents enrolled in training programs. Residents are strongly encouraged to begin utilizing the services of the JBFP early in their training. Prior to placement or referral, the staff provides personal, individualized assistance to the community and the physician in an effort to obtain in-depth information about the needs and desires of both.

Residents and/or requesting physicians may obtain demographic information, community profiles, information about the local medical community, and any other available data needed to decide on a particular community or practice site. In addition, the JBFP maintains a "Practice Opportunities in Georgia" guide which provides information about practice sites available throughout the state. The Board provides this assistance, free of charge, to physicians, residents, and communities who request it.

The Board is fully funded by state funds. It employs two full-time people working in placement (one community representative and one physician representative), clerical staff, plus part-time Director of the Placement Program.

*Program for Assisting Young Physicians Establishing Private Practice*

John Watson, M.D., MAG President, asked the committee to consider several components of a program for MAG to help young physicians establish private practice. His letter, along with suggested specific components, as distributed to committee members, is available upon request.

(a) *Recruitment, Placement, Establishing and Maintaining Practice:*

Dr. Duttera reported on two previous activities of the MAG related to Dr. Watson's recommendation. The MAG decided not to continue a program of this kind in September, 1984, i.e., the Appalachian Regional Grant Program (information in committee files).

In the early 1980's the Access to Medical Care Committee recognized the need to determine problems facing physicians entering practice, as well as why physicians remain or do not remain in a rural or underserved areas. The committee conducted a survey of physicians entering practice in Georgia within the previous five years. The results of this survey reflected similar problems to those being discussed now — the severe stress of the first year of practice; no known source of assistance before setting up practice; business-related practice problems; problems dealing with spouse and family; hospital facilities; geography and community.

The Board of Directors approved several recommendations relating to the use of the study within MAG activities, publications, and other dissemination of its results. It was presented at a conference at Emory. The net result was that it was not very well received by the young students, residents, etc. The committee felt that these young doctors need this kind of help, but don't realize it until they come face-to-face with the "real world."

(b) *Big Brother/Sister Program:*

The committee agreed that the Big Brother/Sister concept is an excellent one, but expressed concern as to how it can be implemented. Committee members felt that unless this is a very personal concern of physicians within the local area, new physicians would most likely not stay. Mrs. Vandiver indicated that the MAG Auxiliary would be very interested in helping with this project.

*Physician Manpower Survey*

Several separate but interrelated actions, i.e., the appointment of a legislative committee to study how to keep physicians in underserved areas; the Joint Board of Family Practice involvement in the legislative committee study; and the expressed concern from the MAG that the physician data being used to determine "need" was insufficient, resulted in the allocation of state funds to allow the Composite State Board of Medical Examiners to conduct a survey to determine where physicians are and what they are doing.

At the time of this report, the survey has been completed and the data are being reviewed to determine what type reports will be forthcoming. It is expected that this data will continue to be updated as part of licensure renewal. The committee agreed that this ongoing study will be an excellent tool to help address maldistribution of medical care. MAG will have access to the data.

*Summary*

At its February 1, 1987 meeting, the MAG Executive Committee approved the following recommendations of the Access to Medical Care Committee:

That the MAG:

1. support the Joint Board of Family Practice Physician Placement Program,
2. continue practice management workshops for residents,
3. explore the possibility of establishing a statewide advisory/coordinating council composed of representatives of the MAG, Joint Board of Family Practice, GHA, Georgia Academy of Family Physicians, interested specialty societies, Medical Fair sponsors, DHR Public Health & Community Services, and the public (legislators, community representatives, etc.),
4. work jointly with the Joint Board of Family Practice toward personal contact with *all* residency programs to promote early involvement with the MAG and the Joint Board, and to assist the residents to plan for the transition into the "real world."
5. consider conducting a seminar in the fall directed toward helping physicians who have recently entered practice in Georgia to meet needs as identified in the 1980 Access to Medical Care Survey and beyond, and
6. contact county medical societies and specialty societies to determine their interest and willingness to participate in the personal one-on-one assistance for the new physicians. In addition, the committee felt that the involvement of the local Auxiliary members would be a major factor in recruiting and retaining a physician.

The Access to Medical Care Committee will continue to pursue these activities and any others deemed advisable by the House of Delegates.

## Committee on the Auxiliary

**William C. Tippins, Jr., M.D., Chairman**

*Committee Members*

William C. Tippins, Jr., M.D., Chairman; John D. Watson, Jr., M.D.; Roy Vandiver, M.D.; Maurice Patton, M.D.; David Thibodeaux, M.D.; Charles Lanford, M.D.; Alva Mayes, M.D.

The committee first met on April 4, 1986 in Atlanta for the purpose of reviewing the Auxiliary's proposed plans for the 1986-87 year and to approve the proposed budget. All members were in attendance with the exception of Dr. Alva Mayes who was out of the state. The respective spouses, Mr. Mike Fowler, Executive Director of MAG and Mrs. Talitha Russell, Auxiliary Director were invited guests.

The second meeting of the committee was at the Post Convention Executive Board Meeting and Luncheon of the Auxiliary on April 26, at Callaway Gardens. The committee members were all present with the exception of Dr. Maurice Patton. The Chairman introduced the members of the committee to the Auxiliary Executive Board. The committee heard presentations on the Spouses of Impaired Physicians Advocacy Program by Edward Waits, M.D.; the Health Improvement Program (HIP) for elementary schools by Morton Harris, a Columbus attorney and the Adolescent Urine Screen for Drugs by Dirk Huttenbach, M.D., Marietta.

The third meeting of the committee will be held in Atlanta at the Annual Convention of the House of Delegates, April 24, 1987.

**Auxiliary Programs and Projects**

*Health Projects*

*Spouses of Impaired Physicians* — Designed and printed a brochure, "Auxilians Helping Auxilians."

*Learning Center* — Phase IV, Cardiovascular materials were added to the existing center. A new catalogue was compiled and distributed to the Auxiliary County Presidents.

*Child Abuse Prevention* — The puppet show "Someone to Talk To" was presented in elementary schools, coloring books were distributed as part of the "It's OK to Tell" Project. A report on the "It's OK to Tell" Project was given at the National Convention of the AMA Auxiliary in Chicago, June 1986 by the Auxiliary President, Mrs. William C. Tippins, Jr. aided by Mrs. Roy Vandiver, President Elect.

*Teen Suicide Prevention* — Materials with information were mailed to County Auxiliary Presidents.

*"You Can Say No," Teenage Sexual Involvement Postponement* — The Auxiliary and the MAG Public Relations Committee designed a two year campaign directed at educating the public and teenagers to the teenage pregnancy epidemic (Georgia ranks fifth in the nation in teenage pregnancies) and the pressures placed on teenagers to become sexually involved before they are mature enough to handle the responsibility for their actions. The two phases of the program included a media blitz to inform and educate through television Public Service Announcements, news releases to radio and newspapers and a press conference kick off day, held at the Academy of Medicine in Atlanta. Speakers at the press conference were: Dr. John D. Watson, Jr., President of MAG, Dr. Marion Howard of the Grady Teen Services, Mrs. William C. Tippins, Jr., President, Auxiliary to the MAG and the keynote speaker, Mrs. Elizabeth Harris, wife of Governor Joe Frank Harris. The second phase included utilizing the Kits developed by MAG containing county statistics, bumper stickers, buttons, brochures "Teenagers, Don't Be Pressured Into Sex" and "AIDS and Teenagers," as well as, pamphlets published by other organizations and teaching the program developed by Dr. Marion Howard, "Postponing Teenage Sexual Involvement" in the public and private schools in Georgia. Plans are being made to form a coalition with other interested organizations for promoting the "You Can Say No Program."

*Substance Abuse* — Bookcovers continued to be distributed in the elementary schools, a puppet show

on Non Use of Tobacco was developed by a county auxiliary for use in elementary schools and educational materials and visual aids were purchased and added to the Substance Abuse Library.

*Medical Society/Auxiliary Projects* — Working together as a team has been encouraged throughout the year. Several projects requiring the participation of both organizations were developed: Urine Drug Screening for Adolescents, Malpractice Support Groups, and the Nutrition Survey.

*Legislative Programs and Projects*

*Key Contact Program* — continued the matching of auxilians with the names of legislators for the purpose of communicating medicine's views on legislative issues, such as Tort Reform.

*Spouse Involvement Program* — based on the PIP (Physicians Involvement Program) auxilians from all over Georgia visited their legislators in the Capitol, talked over pending medically related bills and local issues. They invited their legislators out to lunch whenever possible.

*Legislative Phone Bank* — phones were installed at MAG Headquarters and manned by auxilians from the surrounding area for the purpose of contacting physicians in designated areas requesting that they contact their legislators concerning specific immediate action on pending bills.

*Voter Registration* — Auxilians conducted voter registration booths in strategic locales.

The A-MAG Legislative Chairman traveled over the state visiting county auxiliaries informing them about Tort Reform and other issues.

*AMA-ERF* — Fund raisers such as Holiday Greeting Cards, Auctions, Sale of Georgia Tote Bags, etc. were used to raise money for medical education and research.

*William R. Dancy, M.D. Student Loan Fund* — Georgia project to help medical students with college education, contributions are by the counties. The administration format is being redesigned after an in-depth study of the present method.

*Membership* — An information brochure "Did You Know," listing all the activities and projects of the Auxiliary to MAG was developed. A membership invitation was revised and printed.

*Meetings*

State — Post Convention Executive Board Meetings, April 26, 1986 at Callaway Gardens; Summer Executive Board Meeting, July 14-15, at St. Simons Island; Winter Executive Board Meeting, November 17-18, at Atlanta and the Annual Convention of the House of Delegates, April 24-25 at Atlanta.

*National* — Annual Sessions of the House of Delegates AMA Auxiliary, July 1986, Chicago, two Leadership Confluences, October 1986 and February 1987, Chicago.

*Southern Medical Association Auxiliary* — Annual Meeting was held in Atlanta, the A-MAG acted as hostesses.

**Publications**

*Pulseline* — four issues a year.

*Pulsations* — Newsletter, three issues a year.

*Directory of the Auxiliary* — distributed and mailed to all members.

*Annual Report* — distributed to all members of the Executive Board.

March issue of the *Journal to the Medical Association of Georgia* was the auxiliary special issue.

Sincere thanks are extended to all the members of this committee who served so well throughout the year.

## Building & Land

**H. Duane Blair, M.D., Chairman**

The Building and Land Committee did not meet this year. We continue to believe the value of MAG's Headquarters is enhanced due to rapid development in the neighborhood.

Directly across the street from MAG is a newly constructed 25 floor, 610,000 square foot office building. A multi-story hotel has been erected directly behind this new office building. Considering the nearby MARTA station, we can anticipate continued growth in this area.

What might have seemed to some a poor investment in the late '60s or early '70s, our location now increases in value daily. The Committee will continue to assess real estate values in the area so that appropriate decisions can be made on the advantages of retaining or selling the building.

## Computers in Medicine

**William M. Headley, M.D., Chairman**

Our Committee has met four times during the past year, in Macon, Atlanta and Augusta. Our practice is to feature an educational session with a guest speaker, and to follow with a business meeting.

Excellent speakers have informed us of trends in the computer's applications to medicine: 1) Dr. Abdulla Abdulla, of the Medical College of Georgia, on the use of computers in CME and patient counseling (June 28 and November 15); 2) Mr. Larry Miller, Assistant Vice President of the Blue Cross/Blue Shield Network Group on the Blues' hardware and software packages for physicians in processing insurance claims (August 9); and Ms. Karen Waldo on computer graphics in medicine.

We've also discussed a variety of topics:

*A. GalN* — The Georgia Interactive Network for Medical Information

The Georgia IN system, begun in 1984 by the Mercer University School of Medicine with a grant from the National Library of Medicine, offers physicians immediate access to a vast body of medical information through computer database. Since then, GalN has acquired some 150 subscribers, but recently its NLM grant has ended. Unless a new source of funds or

other assistance can be found, GalN will cease operation this coming June.

*B. Encouraging Physicians' Computer Use*

The Committee believes that the availability of medical databases should encourage physicians' greater use of computers, but we also recognize that most doctors are unfamiliar with "modems" and other equipment necessary to access these databases. We are exploring ways in which we can inform our colleagues of the comparatively inexpensive terminals and readily acquirable skills they would need in order to become "users."

*C. Evaluating Medical Office Packages*

A survey we conducted in the September 1986 *MAG Newsletter* disclosed that MAG members' greatest need from this committee is advice on how to select hardware and software packages for their offices. We hope to remind the membership that Committee recommendations of particular products or vendors are inappropriate, but that selection of the right product or service depends on their practice and individual needs. We intend to begin presenting this information in an article for the MAG *Journal.*

*D. AMA Multiple Payment System (MPS)*

Last year the American Medical Association, in conjunction with a private company in Westlake, Ohio, announced a new computerized system to help medical offices process insurance claims quickly and efficiently. Our Committee reviewed the AMA's announcement of MPS, which included an offer to state medical societies for participation and profit. We discerned problems, at least we raised a lot of questions about major aspects of the system. Accordingly, we recommended that the Executive Committee sign no co-marketing agreement for AMA MPS until more facts are in hand. The Executive Committee approved our recommendation.

Finally, we wish to note with regret the resignation of Ms. Diane Walsh from the MAG staff. Throughout the year Diane has been of much help to this Committee.

And I also wish to thank the members of our Committee, who have contributed much thoughtfulness and expertise to our proceedings:

Abdulla M. Abdulla, M.D., Augusta; James A. Brannon, M.D., LaGrange; Leonard Brubaker, M.D., Augusta; Thomas W. Carswell, M.D., Atlanta; Robert A. Collins, M.D., Americus; David Harvey, M.D., Warner Robins; Charles Ingram, M.D., Atlanta; Kenneth Lindyberg, M.D., Griffin; Sam Mandel, M.D., Macon; William C. Pfister, M.D., Tifton; William Rawlings, M.D., Sandersville; George W. Shannon, M.D., Columbus; Tyson D. Smith, M.D., Covington; Norman Worsley, M.D., Warner Robins; John Zimmer, M.D., Macon.

## Constitution and Bylaws Committee

**J. Rhodes Haverty, M.D., Chairman**

The Constitution and Bylaws Committee met to discuss several proposed changes to MAG's Constitution and Bylaws. Since most of the changes were technical in nature, the Committee recommended that no action on those amendments be taken this year pending a comprehensive review and analysis of both documents prior to the 1988 Annual Session. The Committee requests that any member having any suggested changes please forward them to MAG's General Counsel for review by the Committee.

The Committee took under advisement several resolutions concerning such subjects as (1) establishing a Young Physicians Section; (2) establishing a Specialty Society Section with voting rights; (3) amending Section 1, Chapter XVI, of the Bylaws to allow amendments to be introduced 45 days rather than 75 days prior to the Annual Session; (4) limitations of directors/terms; and (5) authorizing a voting delegate from the Medical Student Section.

The proposed changes concerning the Young Physicians Section and the Specialty Society Section require amendments to the Constitution and to the Bylaws. Article XIII of the Constitution requires that a proposed Constitutional amendment be introduced in the preceding session before the House of Delegates can consider the matter. It will be 1988 before either proposed change can be considered. The other changes concern Bylaw amendments which can be adopted or rejected at the 1987 House meeting. The Committee reviewed each resolution and directed our General Counsel to prepare the appropriate language for the Committee's approval. The language is to be forwarded to the appropriate Reference Committee for consideration along with the proposed resolutions.

## Cost Awareness Committee

**W. John O'Shaughnessey, Jr., M.D.**

The Cost Awareness Committee did not meet this year. It is my recommendation that this Committee be dissolved and that cost awareness activities continue under the auspices of the Georgia Health Network.

I would like to express my appreciation to the members of this Committee who have helped in developing effective cost awareness programs for the membership.

## Maternal & Infant Health Committee

**Luella M. Klein, M.D., Chairman**

The Maternal & Infant Health

Committee is very pleased that the Auxiliary of the MAG made "Postponing Sexual Involvement" a major project for this year. We commend the Auxiliary for this effort and hope it will continue to be implemented throughout the state.

The Committee continues to review maternal deaths. All physicians are urged to be alert for signs of ectopic pregnancies in evaluating their patients. There appears to be an increasing number of assaults and/or homicides either indirectly and directly related to maternal deaths. The Committee will continue to observe this phenomenon.

Several legislative proposals (federal and state) were reviewed:

The October 1986 Federal Omnibus Reconciliation Act includes authorization for state Medicaid programs to cover certain poor pregnant women, infants and children up to 100% of the federal poverty level. The MAG has already supported and the DMA has added some benefits.

However, the DHR and DMA budgets for the next fiscal year went in before this new legislation was passed. The Committee recommended and the Executive Committee agreed to seek legislative action to include the fullest possible benefit for Georgia.

The following statistical data was excerpted from the 1985 Georgia Vital Statistics Report, prepared by the Vital Records and Human Statistics Unit of the Georgia Department of Human Resources in cooperation with the Georgia Center for Health Statistics:

| | *Number* | | | *Rate* | | |
|---|---|---|---|---|---|---|
| | *Total* | *White* | *Black* | *Total* | *White* | *Black* |
| LIVE BIRTHS | 96292 | 62453 | 32769 | 16.2 | 14.7 | 19.3 |
| Age of Mother | | | | | | |
| 10-14 | 466 | 106 | 359 | 2.0 | 0.7 | 4.4 |
| 15-17 | 6220 | 2924 | 3285 | 41.5 | 29.7 | 64.3 |
| LIVE BIRTHS TO UNWED MOTHERS | 24791 | 5874 | 18839 | 17.1 | 5.8 | 42.5 |
| Age of Mothers | | | | | | |
| 10-14 | 428 | 73 | 355 | 1.9 | 0.5 | 4.4 |
| 15-17 | 4095 | 975 | 3114 | 27.4 | 9.9 | 60.9 |
| SPONTANEOUS ABORTIONS OR STILLBIRTHS | 6499 | 4054 | 2374 | 4.5 | 4.0 | 5.4 |
| Age of Mother | | | | | | |
| 10-14 | 39 | 12 | 27 | 0.2 | 0.1 | 0.3 |
| 15-17 | 402 | 202 | 200 | 2.7 | 2.0 | 3.9 |
| INDUCED TERMINATIONS OF PREGNANCY | 32853 | 18837 | 12929 | 22.7 | 18.7 | 29.2 |
| Age of Recipient | | | | | | |
| 10-14 | 480 | 191 | 283 | 2.1 | 1.3 | 3.5 |
| 15-17 | 3788 | 2251 | 1455 | 25.3 | 22.8 | 28.5 |
| BIRTH WEIGHT | | | | | | |
| <1500 GM | 1494 | 635 | 847 | 1.6 | 1.0 | 2.6 |
| 1500-2499 GM | 6279 | 3199 | 3021 | 6.5 | 5.1 | 9.2 |
| 2500-3999 GM | 78838 | 50733 | 27167 | 81.9 | 81.2 | 82.9 |
| >4000 GM | 9681 | 7886 | 1734 | 10.1 | 12.6 | 5.3 |
| OUT OF HOSPITAL BIRTHS | 852 | 438 | 393 | 0.9 | 0.7 | 1.2 |
| TOTAL DEATHS | 48574 | 34999 | 13497 | 8.2 | 8.2 | 7.9 |
| Lifestages | | | | | | |
| INFANCY (<1) | 1222 | 586 | 632 | 12.7 | 9.4 | 19.3 |
| NEONATAL | 827 | 403 | 422 | 8.6 | 6.5 | 12.9 |
| POST-NEONATAL | 395 | 183 | 210 | 4.1 | 2.9 | 6.4 |

## Medical Aspects of Sports Committee

**Letha Y. Hunter-Griffin, M.D., Chairman**

The Medical Aspects of Sports Committee met two (2) times during the 1986-87 year. The committee assigned members to investigate requirements for coach certification in other states. It is the feeling of the committee that certification for coaches in the State of Georgia may be a reasonable goal, although the committee realizes that such certification would require its increased input in formulating certification courses for the coaches. In the next year, the Committee will also inquire of the State Board of Education as to its plans for certification of coaches in Georgia.

The main project of the Medical Aspects of Sports Committee is the formulation of a newsletter. This newsletter was published in September and mailed to coaches, as well as county medical society presidents. Particular interest has been noted on articles entitled *Anabolic Steroids* and *Liability Concerns of Athletic Coaches.*

The committee met in February 1987 to plan for the 1987 *MAG Sports Medicine Newsletter.* Articles will be written by the committee members on a variety of subjects pertinent to the prevention and treatment of sports injuries and illnesses. It is planned that the *Newsletter* will be distributed to all high school coaches and county medical society presidents in July 1987.

Members of the Medical Aspects of Sports Committee have made themselves available to all within the Medical Association of Georgia to advise on any sports related issues, and to assist in obtaining speakers for meetings concerning sports.

## Medicine & Human Values Committee

**Richard Stewart, M.D., Chairman**

Although this committee has not met during this past year, individual members are in the process of selecting one of the increasing number of ethical issues affecting medicine to develop a short position statement and present guidelines to help physicians deal with its ethical/moral components.

These recommendations will be presented to the MAG Executive Committee, Board of Directors, or House of Delegates for approval.

## Non-Physician Health Care Providers Committee

**Richard W. Cohen, M.D., Chairman**

The Non-Physician Health Care Providers Committee met twice during the year. Discussion contènt primarily focused on legislation and regulations relative to non-physician health care providers. The individual committee members proved to be valuable resources throughout the year as various rules and legislation were being developed and debated.

*Physical Therapy Association of Georgia*

At the request of the MAG Executive Committee, representatives of the Physical Therapy Association were invited to discuss their goal of removing the phrase "without consultation with an appropriate licensed practitioner of the healing arts . . . " from Georgia Law, Section 43-33-18 (a) (1).

After extensive discussion, the committee requested that the physical therapists provide the committee with copies of legislation passed in other states, and information regarding the impact of such legislation. Copies of other states statutory language was provided, however the committee felt that further study was necessary to adequately gauge the affect of these laws on quality health care. The committee was very concerned about the broad "scope of practice" language that Physical Therapists would have if the consultation language was deleted. The Physical Therapy Association had legislation introduced this past session, but it did not pass. It is presently being held for study in the House Health and Ecology Committee after passing the Senate.

*Georgia State Board of Chiropractic Rules/Regulations for Use of Electrical Therapeutic Modalities*

It was reported to the committee that the Medical Association of Georgia testified against proposed rules at a hearing to review and comment on the Chiropractic Board's regulations to implement O.C.G.A. 43-9-16 (permitting use of modalities) that passed in 1986. Modifications made as a result of MAG's opposition have been incorporated into the current proposal.

*Joint Practice Committee*

The committee received a report from the Joint Practice Committee in reference to a meeting with nursing representatives held on October 2, 1986 at Georgia Nurses Association headquarters. The Joint Practice Committee suibmitted a request from that meeting that the NPHCP Committee consider recommending that the Medical Association of Georgia approve a resolution calling for the establishment of a Collaborative Care Committee in hospitals.

The NPHCP Committee expressed concern about the concept, and more specifically, the use of language that appears to dictate decisions which are best left to local hospitals. The Chairman of the Joint Practice Committee to discuss these concerns with the Committee and to continue the discussions with the other represented health care providers.

*Occupational Regulation Legislation Review: O.C.G.A.43-1A.*

The stated purpose of this new 1986 law is to "ensure that no programs of licensure and certification shall hereafter be imposed upon any profession or business unless required for the safety and well-being of the citizens of the state." This is commonly referred to as "sunshine" legislation because it calls for at least a one year study prior to implementation of any proposed statute to license or certify a business or profession. It calls for the creation of the Georgia Occupational Regulation Review Council to review all bills as referred from the chairperson of the legislative committee to which a regulatory bill is referred. H.B. 143 providing for the certification of x-ray technologists has been assigned for review this summer.

*Physician Delegation of Medical Acts*

The Committee recommended to the Executive Committee that MAG reaffirm its position supporting a Delegation of Medical Acts Bill. The Committee suggested that such legislation be modeled after the Texas Delegation of Medical Acts Statute. This very broad, non-restrictive proposal would permit any licensed practitioner (i.e., M.D., dentist, podiatrist, chiropractor, etc.) to delegate any act authorized under that practitioner's license to any properly trained person as long as the practitioner was on the premises. The delegating practitioner would remain liable and responsible for the delegated acts. Sen. Roy Barnes of Mableton introduced S.B. 238 as requested by MAG. The bill did not pass this session in part due to opposition from several para-medical groups.

Important delegation language was, however, added to the bill authorizing the extension of the State Board of Examiners for Speech-Language Pathology and Audiology. The 1987 Session saw the "sunset" legislative review of that Board. State law automatically re-

peals (sunset's) state boards up to every 6 years unless a specific statute is enacted to continue the board. It was an opinion by the Attorney General's office regarding physician delegation of hearing tests to non-Board licensed personnel that originated the delegation debate. The newly enacted language overrules the Attorney General's opinion and specifically permits physicians to delegate hearing testing to a non-licensed employee.

*Non-Physician Health Care Providers Committee*

Richard W. Cohen, M.D., Chairman, Austell, GA; William C. Acton, M.D., Macon, GA; Alvin H. Clair, Atlanta, GA; James C. Crutcher, M.D., Lawrenceville, GA; William S. Davis, M.D., Rome, GA; Dennis R. Howard, M.D., Macon, GA; Hans J. Peters, M.D., Columbus, GA; O. Grey Rawls, M.D., Albany, GA; Samuel T. Rice, M.D., Columbus, GA; Jack B. Roof, Jr., M.D., Blue Ridge, GA; Christopher C. Smith, M.D., Albany, GA 31707; Mrs. Phil C. Astin, Jr., Carrollton, GA 30117.

## Occupational Health Committee

**James E. Averett, Jr., M.D., Chairman**

The Occupational Health Committee did not meet last year.

## Physician-Lawyer Liaison

**James A. Kaufmann, M.D., Chairman**

It was not necessary for the entire Physician-Lawyer Liaison Committee to meet this year; however, the individual chairmen for the physicians and for the lawyers did meet to discuss possible joint actions and activities. The major project of the joint group continues to be the revision of the "Principles Governing Physician-Attorney Relationships." An earlier revision was adopted by MAG but the State Bar Association adopted an amended version. Subsequent statutory changes also created a need for further revisions and negotiations. Unfortunately, considerable confusion was created when some entity, apparently within the State Bar Association, published an unadopted version of the "Principles" pamphlet which included MAG's name and implied endorsement. The State Bar Association quickly withdrew the document when notified by MAG and when their own members pointed out the legal inaccuracies it contained. MAG's General Counsel and counsel for the State Bar Association are continuing negotiations to finalize this important project. When the new pamphlet is finally jointly approved, it will be distributed to MAG's membership.

It is also felt that the role of the Liaison will increase because better relations between the two professions need to be augmented. The recent political skirmishes involving tort reform have created unnecessary tensions with some subgroups within the legal profession. It is felt that your Physician-Lawyer Liaison is the proper vehicle for improving those relationships.

## Prison Health Care Committee

**Robert H. DeJarnette, Jr., M.D.**

Dr. DeJarnette continues as Chairperson of this committee, which has met four times during the last year. The committee has cosponsored with the Georgia Chapter of the American Correctional Health Services Association another symposium, held at Jekyll Island, November 14 and 15, 1986. This symposium was attended by 108 medical professionals who practice in correctional institutions throughout the State of Georgia and a few persons attending from South Carolina, Alabama and Florida. Members of this committee who participated in this program by making presentations were: Floyd Bliven, M.D., Augusta; Charles A. Meyer, Jr., M.D., Augusta; and Cassandra Newkirk, M.D., Atlanta.

Funding for the program of accreditation, which is conducted by this committee, has been received under a contract with the Georgia Department of Corrections in the amount of $44,628.00 for the fiscal year 1986-87. Funding at this level is expected to continue through the next year. Additional funding is received by accreditation fees collected for conducting site visits during the year.

Members of the committee remain very active in conducting site visits, assisted by Dorothy Parker, staff person at MAG. This past period they were mostly renewals of accreditation. A number of state prisons entering the program in the previous year were renewed for accreditation. The Department of Corrections is planning to have a few new sites added this year. The first of the sites expected to be added is Lee Correctional Institute in Leesburg, Georgia. Nine state prisons were reaccredited or reviewed during this period.

County jails formerly accredited have continued with renewals also, but with more difficulty in meeting standards than the prisons have. One jail was placed on probation last June, and eventually lost accreditation status. Another was site visited earlier in 1986, but never fulfilled the committee recommendations and thus was not accredited the first time. However, ten county jails were reviewed for accreditation last year and reaccredited.

Dr. DeJarnette was appointed to the Governor's Commission for the Revision of Jail Standards for the State of Georgia. He served on this Commission throughout the summer and fall, attending several working sessions. These standards are total facility standards and encompass much more than medical services alone. The Department of Community Affairs worked with the Commission. Dorothy Parker was

assigned to one of the professional task forces with the responsibility for medical standards. Publication and distribution of the newly revised Georgia State Jail Standards occurred in early 1987. First copies were sent to all sheriffs throughout the state. The DCA has now made available some copies for committee members.

Major revisions have been completed by the National Commission on Correctional Health Care on their standards, which were the former AMA Standards for Prisons, Jails and Juvenile Detention Facilities. Some committee members and Dorothy reviewed drafts of these revisions in June and July, 1986, and submitted to the National Commission their responses and opinions. A number of changes in the draft were recommended in this manner, and some of these changes were implemented in the final drafts, but not all. At this writing, there is some recognition among committee members that the new standards of the National Commission are significantly different and will require more in the way of compliance than the former standards. The MAG Committee on Prison Health Care will be spending the next few months reviewing and making decisions about standards which will become those of the committee to be used in the future accreditation activity. In the meantime, the National Commission standards have been published and distributed, and those facilities which are accredited by the National Commission will need to meet those standards if they are going to be reviewed after May or June of this year. There are only two prisons and three jails in this state which are accredited by the National Commission and four of these facilities hold committee accreditation. The committee has a total of 27 facilities currently accredited under former AMA standards. It is expected that the activity of considering appropriate standards for this committee will be a major activity through the next several months.

This committee appreciates the valuable support given by members of the Medical Association of Georgia and respectfully submits this report and information on the progress experienced during the past year.

## Committee on Specialty Society Relations

**Ellis B. Keener, M.D., Chairman**

The Committee on Specialty Society Relations met once during the past year. The Committee formerly known as the Interspecialty Council, is charged to ". . . maintain communication between MAG and the Specialty Societies." This Committee remains the essential link between the Medical Association of Georgia and the established, recognized (or emerging) Specialty Societies in Georgia as its membership is comprised of appointed representatives from each of the specialty groups.

There are twenty-six (26) officially recognized Specialty Societies in Georgia. There are others who have petitioned for membership on the Committee, which signifies official recognition by MAG. The final decision to admit a new society rests with the MAG Board of Directors.

We had twelve (12) Societies represented at our meeting during the 1986-87 year. They were: Allergy and Immunology; Dermatology; Orthopaedic Surgery; Radiology; Neurosurgery; Public Health; Internal Medicine; Urology; Pediatrics; Pathology; Rheumatism and Gastroenterology.

The Committee continues to feel that one of the most important functions it can carry out is to serve as a forum for the dissemination of the latest available information on new and significant socio-economic developments that have, or are likely to, impact the practice of medicine regardless of specialty.

Clearly no other forum exists to fill this need for the Specialty Societies. It is a function the Specialty Society Relations Committee feels it is performing well and a function we believe is appreciated by those societies who regularly attend Committee meetings.

During the past year Specialty Society representatives have been given an opportunity to get a full briefing on late developments from knowledgeable and responsible spokesmen for the Georgia Health Network (MAG-HMO-IPA), Kaiser-Permanente (closed panel HMO), and HMO Georgia, Inc., the Blue Cross-Blue Shield Health Maintenance Organization.

The member-representatives of the specialties were able to examine up-close the guiding philosophy of the alternate delivery systems presented to them. It learned, for instance, that HMO Georiga, Inc. employs the "gatekeeper" system; it heard the term "triple option" meaning an indemnity plan, overlaid with a PPO and an HMO option.

In addition to the above, the Committee got a full and advanced explanation of the MAG program in tort reform. Hopefully, this played a part in the passage of favorable legislation.

It is the purpose and the hope of the Specialty Society Relations Committee that those who attend meetings will then pass on to the members of their Societies the significant information they have learned.

The face of organized medicine has changed dramatically over the past few years. Specialty Societies have emerged as a vibrant and articulate force for the preservation of private practice. In many instances they have become leaders in the field of medical economics, quality of care, and innovators in medical practice. State Medical Societies in general and the Medical Association of Georgia in particular need to fully recognize these groups as equal partners and enlist their full participation in organized medicine.

I want to thank all the representatives of the Specialty Societies for their active participation on the Committee and most of all to express my appreciation for their continued support of and service to the Medical Association of Georgia.

## Trustee Advisory Committee

**Cyler D. Garner, M.D.**

We have completed conversion of the MAG Retirement Plan to a more predictable money purchase pension plan. This conversion had the dual effect of benefiting our employees while limiting MAG's financial liability should investment earnings not meet expectations.

The new plan provides employees a choice of investments to meet their individual circumstances. However, the new plan does not place MAG at risk beyond the annual contribution of 8% of eligible employee's salaries. This is a significant charge from the previous retirement plan and safeguards the assets of our Association.

## Ad Hoc Committee on Diversion of Legitimate Prescription Drugs

**Milton I. Johnson, M.D., Chairman**

This Committee was quite active during 1985 and presented its resolutions to the Board of Directors in January, 1986. The recommendations were reported to the House of Delegates which declined to implement the recommendations of the Committee.

The Committee members were polled twice during the year by mail and each member was asked if he knew of any business to come before the committee. No member replied in the affirmative and, therefore, no committee meeting was held.

We were expecting a bill to be introduced at the 1987 Georgia State Legislative Session concerning duplicate prescription blanks but, to my knowledge, the bill was not introduced. However, it is expected that a bill will eventually be introduced at a later time possibly by a state agency such as the Georgia Bureau of Investigation or the Drug Enforcement Administration.

*(L TO R) Drs. J. Harold Harrison, William W. Moore, Jr., and E. Napier Burson, Jr.*

## Ad Hoc Committee on Liaison with GOMA

**Alexander H. S. Weaver, M.D., Chairman**

This Committee has not met this year. However, the Osteopathic Association was actively involved in the Tort Reform Initiative.

## Medical Association of Georgia Liaison with MAG Mutual

**John D. Watson, Jr., M.D., Chairman**

This committee is designed to present the ideas, complaints and proposals of our membership to MAG Mutual. The dialogue has already begun, and the cooperative attitude is proper. You have already begun to see some innovations, which will be of benefit to certain categories of our members. This committee is to bridge that gap and not allow lack of communication to become a wedge in our relationship. We each need to know what the other important organization is planning and thinking.

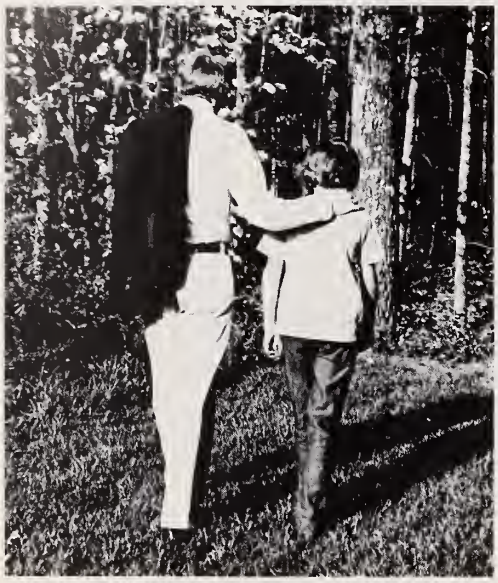
## Ad Hoc Committee on Radiology Technologists

**John D. Watson, Jr., M.D., Chairman**

House Bill 143 was introduced in the 1987 Georgia General Assembly relating to a two-tier system on certification of Technologists. This is the same bill that was offered in 1986. That bill was eventually held in 1986 after elimination of the major portions by special interest groups exempting themselves from the scope of the act.

The bill has been reintroduced as House Bill 143 and forwarded to the Occupational Regulation Review Council, commonly known as the "Sunrise Council" for study, review, approval, and development of forum. If the legislation is recommended by the Sunrise Council and upon completion of any revisions or modifications of the proposed measure, then the Ad Hoc Committee will return the proposal to the MAG Technology Committee, the Executive Committee and the Board for acceptance, modification or rejection.

# At CPC Parkwood, Caring Comes First



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- Eating Disorders Program
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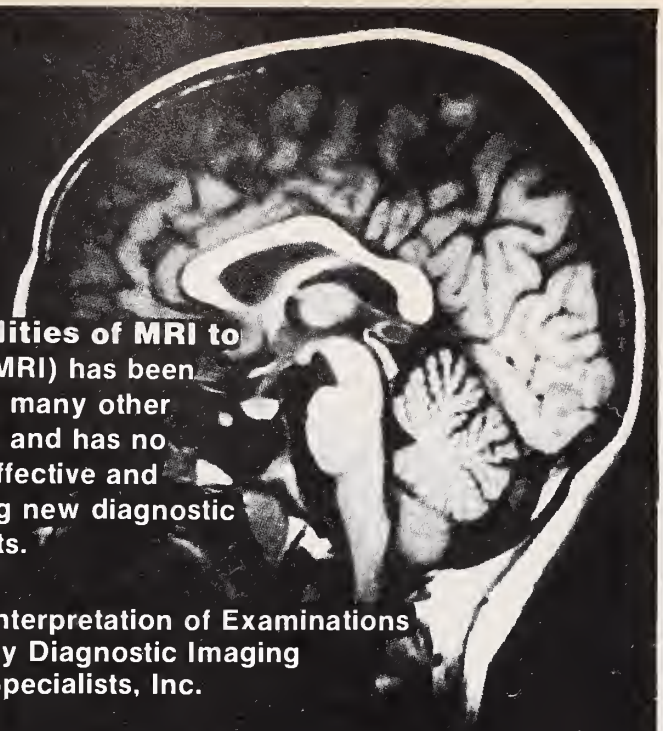

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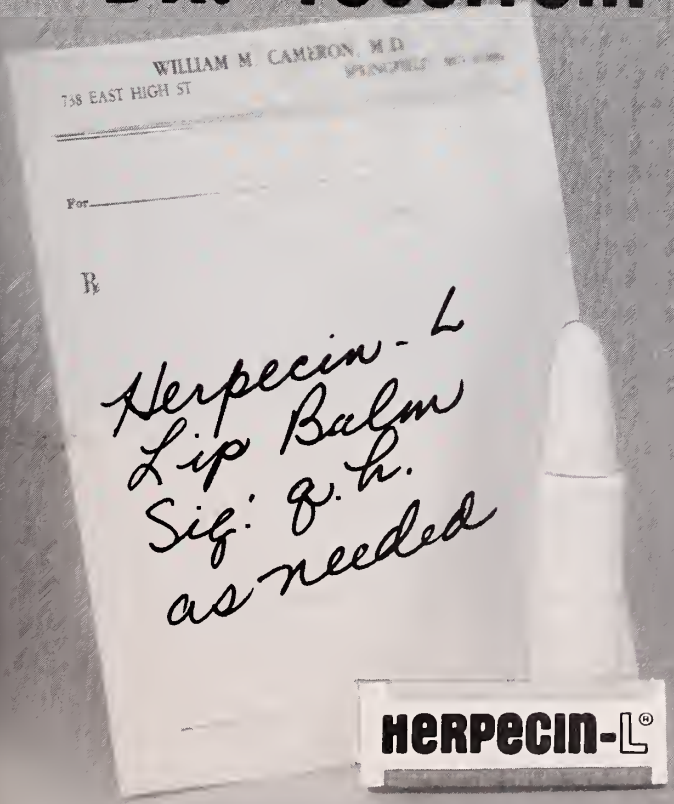


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# SECOND SESSION
## House of Delegates
### April 25, 1987

THE SECOND SESSION of the MAG House of Delegates was called to order at 9:00 A.M., Saturday, April 25, 1987, in the Regency Ballrooms of the Hyatt Ravinia Hotel, Atlanta, Georgia, by Speaker James A. Kaufmann, M.D.

Dr. Kaufmann introduced the distinguished keynote speaker for the 1987 House of Delegates, Dr. William W. Moore, Jr., who addressed the House.

Following Dr. Moore's address, the Speaker introduced John D. Watson, Jr., M.D., President of MAG, for an address to the House which was followed by an address to the House by the President-Elect of MAG, Jack F. Menendez, M.D.

Following Dr. Menendez, the Speaker called for a report from the Credentials Committee which was given by James H. Sullivan, M.D., Columbus. Dr. Sullivan reported that 203 delegates and 15 alternate delegates were present, representing 41 component county medical societies. As provided in Chapter III, Section 3 of the Bylaws, a quorum was present.

*JOHN D. WATSON, JR., is presented with a bound volume of the* MAG Journals *containing his President's Pages written during his term of office.*

ANNOUNCEMENT OF ELECTION REPORTS

The Speaker announced that the results of the 1987 elections are as follows:

*JACK F. MENENDEZ, of Macon, assumes the Presidency of MAG.*

*President-Elect:* Joseph P. Bailey, M.D., Augusta
*Second Vice President:* Richard W. Cohen, M.D., Atlanta
*Treasurer:* Cyler D. Garner, M.D., Gordon
*Secretary:* Ralph A. Tillman, M.D., Lawrenceville.
*AMA Delegate:* C. Emory Bohler, M.D., Brooklet.
*AMA Delegate:* Charles D. Hollis, Jr., M.D., Albany.
*AMA Delegate:* William W. Moore, Jr., M.D., Atlanta.
*AMA Delegate:* F. William Dowda, M.D., Atlanta
*AMA Alternate Delegate:* L. Newton Turk, III, M.D., Atlanta.
*AMA Alternate Delegate:* Virgle W. McEver, Jr., M.D., Warner Robins.
*AMA Alternate Delegate:* C. Peter Lampros, M.D., Toccoa.
*AMA Alternate Delegate:* William D. Logan, Jr., M.D., Atlanta.
*AMA Alternate Delegate:* E. M. Molnar, M.D., Columbus.

## REFERENCE COMMITTEE REPORTS

The Speaker made various announcements about procedures involving Reference Committee Reports.

Prior to the first Reference Committee Report, the following policy statement and related motion was presented by the Speaker to the House as follows:

"It has long been the spoken, yet unwritten policy of the House of Delegates for this and prior sessions that only the recommendation and resolved portions of the various resolutions and reports, including the Reference Committee Reports, have been considered for adoption by the various Reference Committees and by the House of Delegates. Conversely, the other portions of the said resolutions and reports have not been adopted by either the Reference Committee, nor by this House, nor have they even been considered by either body. All such preliminary language, preambles, "whereas" paragraphs, committee statements, explanations, attachments etc. are the singular opinions, statements, expressions, etc. of the author of the report or resolution, and are not and should not be considered to be the product or position of the Medical Association of Georgia, nor does MAG assume any responsibility for the contents and statements contained herein."

*NEWLY INSTALLED MAG President Menendez and Immediate Past President Watson.*

*DR. JOHN WATSON bids farewell as he ends his 1986-87 term as President of the MAG.*

Motion was made that the above statement be unanimously adopted as MAG policy. Said statement was unanimously adopted.

NEW BUSINESS

By acclamation, the House extended its appreciation to Speaker Kaufmann and Vice Speaker Raines for their expertise in presiding over the activities of the MAG House of Delegates and to the MAG staff for its efficiency in coordinating all the functions required for a successful meeting.

ADJOURNMENT

There being no further business, the Speaker adjourned the 1987 House of Delegates at 4:30 P.M.

# A Personal Perspective Regarding Medical Organizations

DR. KAUFMANN, ladies and gentlemen of the Medical Association of Georgia, thank you for the honor of addressing this group. Dr. Kaufmann indicated a recognition of my Presidency of the Southern Medical Association. I must also thank the membership and officers of that Association for giving me the opportunity of serving them. Today, I know that I'm "Preaching to the Choir," but I would like to pass on a few personal thoughts regarding medical organizations that I've acquired since 39 years ago, 1948, when I joined the Fulton County Medical Society as a non-voting, non-dues paying Resident member. Since then, I've been closely involved with our Local, State, and National "organized" medical associations as well as Local, State and Regional professional societies with a couple of International societies and a somewhat different breed of cat — the Southern Medical Association. It differs principally in that it excludes any political activity and primarily focuses on education, both medical and socioeconomic, and on providing a wide range of membership benefits, some of which return a profit that is used for the educational efforts. I've learned that good education demands subsidy in some form — endowments, contributions or taxes — and to expect otherwise is to court financial failure. If you don't believe me, ask the educators from top to bottom.

Many physicians feel that there are too many organizations. My own perception is that they only exist because of a recognized need. If any of the groups with which I've been involved were to be dissolved, they would be resurrected shortly for this reason, perhaps with a different name but for the original reasons for being.

Much has been made of the fact that fewer than 10% of the members of any medical organization play any significant role in their operation. Let me try to dispel that myth. The 90% of members frequently referred to as the disinterested, the apathetic, the non-doers, the complainers, and in other derogatory terms are, in fact, the whole skeleton and much of the muscle and flesh of the organism. They are the people who have by their free will, not coercion and not by any financial reward, given over to the 10% their backing and financial support and who allow by their simply being there an organization to be effective through the actions of its officers.

Another myth I think needs laying to rest is that compromise is a dirty word. This comes out of failure to recognize the vast differences among us. Just because we have in common an M.D. degree, more years of education and training than most, and possibly a little more good will toward humanity than some — we are far from being alike in thought or philosophy. This very House of Delegates and more vividly because of its national extent and size — the AMA House of Delegates — has taught me to be wary of carrying the "only truth." I have found too many times to my embarrassment that not only were other opinions about a subject valid, they were usually much better and more valid than mine. The art of hammering out policies acceptable to a majority demands a recognition of and a respect for the differences among us as well as a concentration on those areas where we can agree in order to develop effective policies and actions. Nowhere does this call for an abrogation of principles or of any element of sellout. Casey Stengel said it best, "It's easy to get the players. Getting them to play together — that's the hard part."

In summation, to you who constitute the delegated few and to those who did the delegating — who elected you, I commend to you the "marathon philosophy" — Keep going, never stop and try not to do anything stupid.

*William W. Moore, Jr., M.D.*
*President*
*Southern Medical Association*

*This article was the Keynote Address of the Second Session of the 1987 MAG House of Delegates.*

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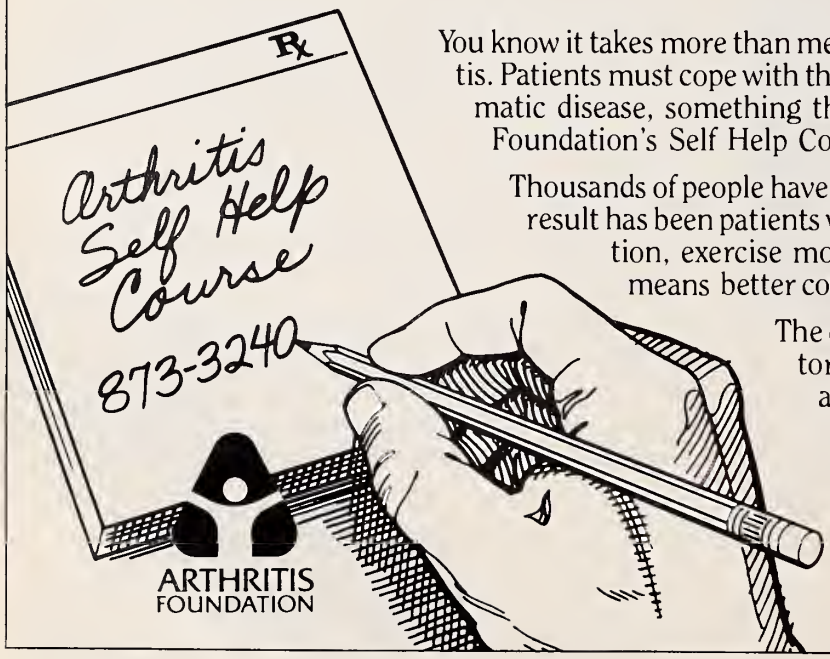


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# REPORT
# Reference Committee
# A

*PHILIP Z. ISRAEL, a general surgeon from Marietta, was Chairman of Reference Committee A.*

*The following physicians were members of Reference Committee A: Philip Z. Israel, Chairman, Cobb; E. V. Herrin, Vice Chairman, Crawford W. Long; Alan Plummer, Medical Association of Atlanta; Edward H. Smith, Richmond; Roy W. Vandiver, DeKalb; John Richmond, Whitfield-Murray; Kenneth L. Goldman, Muscogee; and Corinne F. Quinn, Guinnett-Forsyth.*

## *Secretary*

**Ralph A. Tillman, M.D.**

It doesn't seem possible — but another year has swiftly passed us by and is now history. Reflection on those twelve months could easily be discouraging and depressing, but careful sifting through the remains of battle reveals some victories for our beleaguered profession. I will leave it to others to dwell on those victories and varied accomplishments of days gone by and devote some attention to the immediate future. Looking ahead at the major problems and threats to the "House of Medicine" presents challenges for which there appears to be little hope for optimism. But in spite of this — with dogged determination, dedication, and *some element of unity* — optimism and a ray of hope must, and shall prevail!

A few years ago one of our past presidents, Dr. Earnest Atkins, wrote an editorial concerning the "Fall of the House of Medicine." The major thrust of what he was saying (as I recall) is that without some element of unity within our ranks nothing could have (nor will ever be) accomplished that can be viewed as a plus for our profession. Never has there been a greater need for unity in medicine than *now.* For never has the "House of Medicine" faced so many entities that threaten us with more divisiveness and lack of unity.

Without any elaboration, permit me to enumerate what I perceive to be frontal assaults on the "House of Medicine" — not necessarily in any order of significance or severity:

1) malpractice litigation and its devastating impact;
2) 3rd party intervention:
   — Alternative Health Care Systems (HMO's, SHMO's, IPA's, PPO's, etc.)
   — Governmental (Medicaid, Medicare, CHAMPUS, DRG's, RAP-DRG's, MAAC's, mandatory participation, proposals for catastrophic

health insurance, capitation, etc.)
- Cost control and review measures of above, Blue Cross/Blue Shield, and other commercial insurance carriers (preadmission certification, mandatory 2nd opinion, concurrent reviews, retrospective denial of payment, mandatory generic substitution, A.M. admission requirements, fee setting, requirements for services to be in on outpatient setting and on and on, ad nauseum)
- For profit (solo and/or joint) ventures
- Over abundance of physicians
- Impaired, incompetent physicians
- Failure of the "House of Medicine" to properly address certain glaring and major problems such as health care for the indigent, drugs, child and elders abuse, teenage pregnancy, AIDS, etc.
- A never-ending bondage of onerous legislative proposals that would affect some element of our profession and have a negative impact on the "House of Medicine."
- Apathy, disunity, disillusionment with the leadership of the "House of Medicine."

We have common antagonists, common problems, common goals; we are all bound by common ties, a common devotion to healing and to making this world a better place in which to live. *Together,* ignoring whatever label we or our fellow physicians choose to wear, we can accomplish most anything. However, if we choose to disassociate ourselves, go a separate direction, not be united, there will be few, if any significant victories.

'Tis not in numbers but in *unity,* that our great strength lies.

*Thomas Paine*

*RALPH A. TILLMAN, of Norcross, is Secretary of the MAG.*

**Membership Comparison**

| | *1986* | *1985* | *1984* | *1983* | *1982* |
|---|---|---|---|---|---|
| Active | 5208 | 5056 | 4879 | 4813 | 4559 |
| Active Resident | 376 | 357 | 125 | 86 | 83 |
| Affiliate | 7 | 7 | 7 | 9 | 10 |
| Associate | 58 | 62 | 53 | 51 | 44 |
| DE-1 (financial hardship/illness) | 54 | 48 | 48 | 50 | 55 |
| DE-2 (post-grad training) | 2 | 2 | 3 | 3 | 5 |
| DE-4 (temporary military) | 2 | 2 | 4 | 4 | 6 |
| DE-5 (life) | 262 | 257 | 264 | 247 | 251 |
| DE-7 (over 70) | 89 | 87 | 74 | 116 | 99 |
| Retired | 304 | 241 | 197 | 167 | 133 |
| Service | 56 | 62 | 63 | 59 | 57 |
| Student | 93 | 50 | 6 | 13 | 2 |
| | 6511 | 6231 | 5723 | 5618 | 5304 |
| AMA Membership* | 3289 | 3416 | 3776 | 3719 | 3709 |

* The above AMA membership figures reflect only those AMA members who pay AMA dues via MAG.

Behold, how good and how pleasant it is for brethren to dwell together in *unity.*

*Psalms 133:1*

With strong grass roots support, proper leadership, prudent planning *and* a unified front, wouldn't those threats to the "House of Medicine" be a bit less ominous?

**Recommendation**

1. Let's seek that degree of unity at all levels — local, state and national!

**House Action**

Adopted with commendation.

## Speaker

**James A. Kaufmann, M.D.**

This 133rd Annual Session of the Medical Association of Georgia House of Delegates convenes with Dr. Raines and myself as your new presiding officers. We begin our terms with a commitment to continue the admirable precedents established in preceding House sessions, and strive to insure that the House offers an opportunity for *every member* of the Association to express his or her viewpoints.

This spring we have accordingly expanded our coverage of the upcoming House with a more detailed "Official Call" in the March issue of the *Journal of the Medical Association of Georgia.* We have also increased publicity for our House in both the March and April issues of the *MAG Newsletter.* We have encouraged non-delegate members to participate in our House proceedings, especially at Reference Committee hearings and at our Annual President's Reception, honoring Dr. Watson. And for our Reference Committees we have drawn members from across the state, attempting the most democratic representation of our county medical societies.

And we are also attuned to the comfort of our delegates, alternates and guests while at the Hyatt Ravinia Hotel. We have taken elaborate pains to ensure congenial, efficient service by the hotel staff. Following this House meeting, the Annual Session Committee will be deciding sites for future House meetings, so we encourage all attendees at this meeting to let us know your opinion of this, as well as other prospective meeting sites.

The House of Delegates is MAG's legislative body, responsible for shaping the policies which guide our Association from year to year. The Annual Session Committee will continue its work in helping to make our upcoming House meetings as responsive to the needs of our membership as we can.

**Recommendation**

That the MAG Annual Session Committee, in cooperation with the Board of Directors, develop strategies to provide for greater participation by the general MAG membership in the annual meeting of the House of Delegates.

**House Action**

Adopted with commendation.

## Public Health Committee

**O. Grey Rawls, M.D., Chairman**

Through its activities this past year, the Public Health Committee continues its efforts in promoting improved public health in Georgia. Actions have been channeled in the following areas:

*AIDS Physician Education*

In July, 1986, the committee developed a MAG AIDS Action Plan which called for the development of an AIDS Physician Education Program and speakers bureau, and informational reports to inform the MAG Board and membership of developments in this critical public health problem. In January, 1987 an update was provided to the MAG Board on Association activities on AIDS. Excerpts from that report are as follows:

The number of confirmed cases of AIDS continues to grow in the State of Georgia, rising from some 167 confirmed cases reported in 1985 to 297 cases in 1986. By 1991, it has been estimated that Georgia may have as many as 3,000 active cases of AIDS. Another 3,000 persons will have died with AIDS during the first decade of this disease. Reference is made to AMA AIDS Status Report L to the House of Delegates of the AMA Interim meeting, 1986, for further information.

In an effort to develop strategies for combating AIDS and minimizing its transmission, the State Board of Human Resources directed the Department of Human Resources to appoint a State Task Force on AIDS. The Task Force, established in the fall of 1985, consists of 23 appointed members who represent multiple disciplines, many of whom are Association physicians involved in AIDS research, administration, and/or clinical practice. In conjunction with this committee and the DHR AIDS program, MAG's Public Health Committee has spent considerable time over the past six months in developing a Physician AIDS Training Module which will be ready for use in May or June of this year. The program will offer an assortment of informational brochures, slides, videotapes, and texts for physician education and training.

To further enhance physician education, the committee contributed in dedicating the January, 1987 issue of the *MAG Journal* to the topic of AIDS. This spanned a wide breadth of topics from current epidemiologic findings and treatment to the psychosocial aspects of AIDS.

On February 19-21, 1987 the MAG cosponsored the International Conference on AIDS with the Emory University Department of Pediatrics, bringing together AIDS researchers, educators, and physicians from throughout the world to examine and discuss AIDS and the heterosexual and child and adolescent patient populations. On March 12 and 13, 1987 the Association culminated its program year by hosting the second AMA Regional Conference on AIDS for physicians from eight southeastern states; the workshop focus being to create physician speakers bureaus to provide public information within each state. In February, 1987, MAG, through careful study by the Public Health Committee, submitted comments to the Department of Human Resources in support of the voluntary testing of pregnant women or those who may become pregnant

who are at high risk, and mandatory testing of convicted prostitutes as an epidemiologic surveillance and tracking system.

In summary, the committee will continue to carry out activities of the MAG AIDS Action Plan emphasizing the high visibility of a physician AIDS education program that encourages district and county medical societies to recruit and train physicians as community resources for information about the medical and social consequences of AIDS.

*MEMBERS SERVING ON REFERENCE COMMITTEE A included (L to R): Edward H. Smith, Richmond; Alan Plummer, M.A.A.; Roy W. Vandiver, DeKalb; and Corinne F. Quinn, Gwinnett-Forsyth.*

*Hepatitis B Virus Education*

In recognition of the growing number of outbreaks of Hepatitis B virus in patients of infected dental, medical, and surgical practitioners and because of the present low immunization rates among many high risk physicians and their patients, this committee launched a statewide Hepatitis B educational program in June, 1986. Consequently, the committee and MAG cosponsored a symposium on October 21, 1986 at St. Joseph's Hospital, Atlanta, on "Meet the Experts on Hepatitis." In cooperation with epidemiologists at the U.S. Centers for Disease Control, physician tapes on Hepatitis B were announced and distributed to interested physicians, as well as the commissioning of an article on the topic for a spring publication in the *MAG Journal.*

*The MAG Health Risk Appraisal Project*

In February, 1986 the Medical Association of Georgia, through its Public Health Committee and the Georgia Department of Human Resources, initiated a pilot health risk assessment program in six randomly selected high schools throughout the state as a means of determining particular health risks that affect teenagers. In July, 1986 the results of the project were compiled and published — offering much needed information on health issues related to nutrition, alcohol, drugs, tobacco, stress, and exercise. The information lent significant impetus to strides in developing programs to meet the needs of teenagers. (Reference is made to the MAG news release of Thursday, July 3, 1986 for highlights of these findings.)

The committee further assisted in the revision of the risk profile test form and in the development of a new computer program. The MAG Auxiliary worked hand-in-hand with the committee and members of county medical societies in administering the questionnaire and providing follow-up counseling and referrals. The assessment program was continued in the fall of 1986 in school systems throughout northeast Georgia with plans to implement the program throughout the state during 1987.

In view of the aforementioned information, the committee offers the following recommendations for consideration by the 1987 House of Delegates:

**Recommendations**

1. That the MAG urge all physicians to become knowledgeable about HTLV-III and that the Association work in cooperation with county and district medical societies to provide useful and timely educational materials in order that physicians may take a major part in educating the public.

2. That the MAG urge governmental agencies and appropriate laboratories in private industry to intensify and expedite their research and development of standardized confirmatory tests for Acquired Immune Deficiency Syndrome in order that such tests can be made uniform, reproducible and standardized and available to most clinical and hospital laboratories, so that they can be used in mainstream medical practice rather than being limited largely to a small number of laboratories and aimed primarily at public health usages.

3. That the MAG endorse the position that persons in all categories at high risk of Acquired Immune Deficiency Syndrome (AIDS) be encouraged to be tested for Human T-Cell Lymphotropic Type III (HTLV-III) Antibody for purposes of counselling.

4. That the MAG oppose acts of categorical discrimination against AIDS patients, HIV Seropositive individuals and persons at increased risk of developing AIDS.

5. That MAG endorse the position that the confidentiality of patients infected with HTLV-III should be

protected. When a patient is known to be infected with HTLV-III as defined for reporting purposes by the Center for Disease Control or relevant state health bodies, this information should be reported to appropriate health authorities. Beyond mandated reporting requirements to the appropriate public health authority, however, the occurrence of a confirmed positive result in a serologic test for antibody to HTLV-III should not be communicated by health professionals to any other non-health professional except the patient whose blood has been tested.

6. That MAG commend the DHR Georgia Task Force on AIDS for their work in developing state strategies for combating AIDS and minimizing its transmission, and offer our support in any way feasible.

7. That the MAG recommend to medical specialty societies that:

a. they urge susceptible physicians and other members of the health professions, especially those involved in invasive procedures, to seek out immunization against Hepatitis B virus, and
b. physicians in proposing prophylaxis with either the plasma-derived or the recombinant DNA Hepatitis B vaccine include in their consideration persons in the following susceptible pre-exposure categories: health care personnel, homosexually active men, intravenous drug abusers, heterosexual men and women with multiple sex partners and other high risk groups.

8. That the MAG Auxiliary be commended for their considerable effort in assisting with the High School Health Risk Appraisal Project and in providing broader information to educational authorities for guidance in instructional areas.

**House Action**

*Recommendation 1:* Adopted as amended to read:

*"That the MAG urge all physicians to become knowledgeable about* HIV *and that the Association work in cooperation with county and district medical societies to provide useful and timely educational materials in order that physicians may take a major part in educating the public."*

*Recommendation 2:* Adopted.

*Recommendation 3:* Adopted as amended to read:

*"That the MAG endorse the position that persons in all categories at high risk of Acquired Immune Deficiency Syndrome (AIDS) be encouraged to be tested for* Human Immunodeficiency Virus (HIV) *antibody for purposes of counseling."*

*Recommendation 4:* Adopted as amended to read:

*"That the MAG oppose acts of* unfounded bias *against AIDS patients, HIV Seropositive individuals and persons at increased risk of developing AIDS."*

*Recommendation 5:* Adopted as amended to read:

*"That MAG endorse the position of protecting HIV Seropositive patients with the same standards of confidentiality practiced on patients with all other communicable diseases, and encourage the addition of AIDS to the list of reportable diseases."*

*Recommendation 6:* Adopted.

*Recommendation 7a:* Adopted.

*Recommendation 7b:* Adopted as amended to read:

*"Physicians in proposing prophylaxis with either the plasma-derived or the recombinant DNA Hepatitus B vaccine include in their consideration persons in the following susceptible pre-exposure categories,* including, but not limited to: *Health care personnel, homosexually active men, intravenous drug abusers, heterosexual men and women with multiple sex partners and other high risk groups."*

*Recommendation 8:* Adopted with commendation.

*Additional amendment introduced on the floor of the House and referred to the MAG Board of Directors:*

That MAG encourage exchange of information regarding a patient's infectious potential between physicians and other health care professionals who are involved in the care of the patient.

That MAG seek legislative relief of the confidentiality issue regarding notification of persons at risk (e.g., spouse) when a physician is aware of a patient infected with HIV.

## Public Relations Committee

**Jeffrey T. Nugent, M.D., Chairman**

*Referred to: Recommendation 1 — Reference Committee C, Recommendation 2 — Reference Committee A/F.*

At the 1986 meeting of the Medical Association of Georgia House of Delegates, the Public Relations Committee recommended an assessment of the membership for $100.00 for a Tort Reform Public Education Campaign, and direction to the House of Delegates to make the involvement for the Governor of the State of Georgia a primary goal in the 1987 Campaign. The House of Delegates in its final action, approved a $200.00 per member assessment, and charged the Executive Committee with forming a Tort Reform Planning Committee, to be made up of representatives from the Medical Association of Georgia, MAG Mutual and the Auxiliary to the MAG, to oversee activities of a Tort Reform Campaign. Dr. John Watson, President, was appointed Chairman. The MAG-PR Committee worked with the outside consulting firm of Lewis, Clark and Graham, in developing Public Relations materials for the Tort Reform Campaign with all the material being finally approved by the Tort Reform

Committee and the Executive Committee of MAG. The culmination of the effort was the "Physician's Survival Kit" which was mailed to all Georgia physicians. Fifty copies of the brochure used to explain reasons why the Medical Association of Georgia and the Georgia Liability Crisis Coalition were seeking eight specific measures of Tort Reform in 1987, were mailed to each physician. The phrase "Warning: Excessive Liability Costs May be Hazardous to Your Health" was printed on all badges, press kits, pamphlets and other mailings from MAG.

The Public Relations Committee assisted in fielding questions from the media on Tort Reform by designating appropriate spokespersons and by helping MAG members formulate editorial responses to various newspapers, TV and radio stations throughout Georgia. The Committee developed, disseminated, and tabulated the second annual Survey on Physicians and the Liability Crisis and we added to the survey a Resident Physician's Poll. These findings were reported in the December *Journal of MAG* and released to the public that same month.

Working with the Georgia Liability Crisis Coalition, we hired Darden Research Corporation to poll businesses in Georgia regarding effects of the liability crisis. We helped to assemble a press conference at the Capitol to release the results.

*"You Can Say No" Teenage Pregnancy Prevention Campaign*

The PR Committee and staff, in conjunction with MAG's Auxiliary, has worked extremely hard to develop and implement this campaign. We began back in May of 1986 by researching and collecting data on teen sexual involvement and pregnancy in Georgia, and discovered that:

1) Georgia ranks fifth highest in the nation in the number of teenage pregnancies; and
2) over one half of all Georgia teens, 15-19, are believed to be sexually active.

Over the next eight months we worked with Marion Howard, Ph.D., of Grady Teen Services and completed the following:

1) wrote and edited materials for our campaign kits which included: state and county fact sheets, editorials, feature stories, television and radio public service announcements, and brochures;
2) developed campaign press kits, bumper stickers and buttons signifying the theme of our campaign: "You Can Say No," Teenagers, Don't Be Pressured Into Sex;
3) we disseminated "Leadership Kits" and information to all county medical society and county auxiliary presidents explaining the campaign in detail, for use in their local areas;
4) we selected volunteer teen actors, developed and produced two television public service announcements;
5) and we prepared for the January 21, 1987 kick-off press conference.

The press conference was extremely successful. Approximately 115 people attended, including 4 TV stations, 3 radio stations and 3 newspapers. The conference agenda featured Dr. John Watson, MAG President; Mrs. Barbara Tippins, the Auxiliary Present; Dr. Marion Howard of Grady Teen Services whose educational series, Postponing Sexual Involvement, is being used in Georgia schools; and Mrs. Joe Frank Harris, who was our keynote speaker. We also featured the premier showing of our TV spots, and two teen actors from Brown High School in Atlanta acted out a scenario of teen "pressure lines" and appropriate responses for the conference attendees.

The news of our campaign was well received and there have been numerous follow-up calls from the press and other interested parties. The next step is the formation of a coalition of various groups currently involved in working with teenage pregnancy, to assist the Auxiliary in getting the educational series into all Georgia school curriculums.

*Other Activities MAG's PR Committee Has Been Involved in This Year*

1) Following the House of Delegates in April, we distributed some of the house actions, in the form of press releases, throughout the state. Approximately 10 newspapers picked up this information which included our action on the steroid issue.
2) Our PR staff met with the medical reporters in Atlanta, Savannah, Augusta, Macon, and Columbus — some of whom are new to the medical/science beat — as part of an ongoing effort to foster good relations with the press.
3) We continued, in a lesser role, assisting the Georgia Society of Ophthalmology (GSO) in obtaining publicity for their National Eye Care Project for the elderly.
4) We wrote monthly radio public service spots on topics such as the tobacco ban and tort reform for Dr. Harrison Rogers to read on WGST radio in Atlanta.
5) And we became involved in launching a new Organ Donation program developed by a coalition stemming from the Public Relations Society of America — Georgia Chapter.

MAG's Public Relations Committee met five times during this past year. The Chairman wishes to thank the following members of the Public Relations Committee, who have unselfishly given a great deal of their time and efforts to these projects during the past year: Kathy Easterling, M.D.; James G. Killebrew, Jr., M.D.; Thomas A. Lyons, M.D.; Charles W. McDowell, Jr., M.D.; Christian R. Moorhead, M.D.; Toby S. Morgan, M.D.; Alan Pomerance, M.D.; Beverly B. Sanders, Jr., M.D.; Gerald Stapleton, M.D.; Joseph W. Stubbs, M.D.; Mrs. William C. Tip-

pins; William Weston, M.D.; Edgar Woody, M.D.

**Recommendations**

1. The Public Relations Committee recommends that the remainder of the unspent funds from the 1986 assessment of membership for a Public Education Campaign for Tort Reform be maintained in a separate account for a continued effort in 1987 and 1988 to further obtain key Tort Reform Legislation, which was not passed by the Georgia Legislature in 1987. Particularly important to us is a limitation on pain and suffering awards, structured settlements, attorney contingency fee regulation, and any other elements of Senate Bills 1 and 2, which were not passed by the Legislature.

2. We request a $50,000 budget for 1987-88 for two purposes: primarily to continue with the program co-sponsored with the MAG Auxiliary entitled "You Can Say No," Teenage Pregnancy Prevention Campaign, and secondly to develop a Public Education Campaign concerning the responsibility of the citizens of Georgia to take charge of their own preventive health lifestyle practices, develop price consciousness in the purchase of health services, and promote understanding of the elements of quality health care.

**House Action**

Adopted the following substitute amendment in lieu of Recommendation 2, Resolution 11, and Resolution 16:

*"The Public Relations Committee requests a $50,000 budget for 1987-88 for the following purposes: to continue with the program co-sponsored with the MAG Auxiliary entitled, "You Can Say No," a Teenage Pregnancy Prevention Campaign, and to develop a Public Education Campaign concerning the responsibility of the citizens of Georgia to take charge of their own preventive-health, life-style practices* in the areas of fitness, smoking, nutrition, and sexually transmitted diseases including AIDS, *to develop price consciousness in the purchase of health services, and promote understanding of the elements of quality health care."*

See Report of Reference Committee C for House Action on Recommendation 1 and Report of Reference Committee F for further action on Recommendation 2.

## Ad Hoc Committee on Chiropractic Education

**J. Rhodes Haverty, M.D., Chairman**

This committee was appointed in 1984 and charged to "assimilate information on the current scope of Chiropractic education, which information will be used to provide to the Georgia legislature if the need arises."

1984-86 catalogues from each of the 13 U.S. Chiropractic Schools and the Canadian Memorial Chiropractic College in Toronto were received and reviewed by MAG staff. This information is maintained for legislative purposes only. It has not been distributed.

**Recommendation**

1. That this committee be officially abolished.

**House Action**

Adopted as amended to read:

*That this committee be officially abolished, with the recognition that any Ad Hoc Committee can be reestablished as deemed necessary.*

## Ad Hoc Committee on Composite State Board of Medical Examiners

**William C. Collins, M.D., Chairman**

This committee's charge is to work with the Board of Medical Examiners in recommending any changes necessary to assure due process for physicians who may be under review by the Board.

The Board of Medical Examiners is governed by the same procedural rules that govern the other state examining boards as incorporated in the Rules of the Joint Secretary, State Examining Boards, Chapter 295-3 through 295-13. These rules stipulate that the Board is subject to the Georgia Administrative Procedures Act, O.C.G.A. 50-13, which contains very explicit due process procedures and is applicable to all state agencies that have the authority to take adverse action against any individual.

This committee was appointed in response to a request from physicians who felt they had not been given due process before an adverse decision of the Board of Examiners was made. In this instance, it was learned that the physicians had not understood the procedures.

The committee met with legal counsel to review the Board's due process procedures. It was determined that no need for any legislative or rule/regulation changes is indicated at this time.

Members of the MAG Board of Directors were asked to refer any physicians who were having problems with the Board of Medical Examiners to this committee. If sufficient numbers had been referred, we would have conducted an educational program to help them understand and follow through with the Board of Medical Examiners' established procedures. None were received.

**Recommendation**

1. That this committee be officially abolished.

**House Action**

Adopted as amended to read:

*That this committee be officially abolished with the recognition that any Ad Hoc Committee can be reestablished as deemed necessary.*

## Ad Hoc Committee for Tort Reform

**John D. Watson, Jr., M.D., Chairman**

MAG's Ad Hoc Committee for Tort Reform was formed in 1986 for the purpose of assisting in carrying out any plans of action regarding tort reform authorized and delegated by the MAG Executive Committee. Throughout the year, this committee coordinated efforts on behalf of the Legislative Committee, the Public Relations Committee, MAG Mutual, and the Georgia Liability Crisis Coalition, and made recommendations to the MAG Executive Committee for a uniform plan of action.

Due to the expertise and informed view of the members of the Ad Hoc Committee for Tort Reform, MAG was able to develop a polished, professional campaign with strong, grass roots support. The end result, a comprehensive package of tort reform approved by the Georgia Legislature, was due in large part to the hard work of this committee.

**Recommendations**

1. That the MAG House of Delegates commend members of this committee for their dedication to the goal of improving the liability climate in Georgia and their success in making inroads toward this goal. The members are: Sam O. Atkins, Atlanta; William C. Collins, Atlanta; Ernest C. Fokes, Decatur; Charles D. Hollis, Jr., Albany; James A. Kaufmann, Atlanta; William D. Logan, Jr., Atlanta; Jeffrey T. Nugent, Atlanta; Beverly B. Sanders, Jr., Macon; Ralph A. Tillman, Lawrenceville; Mrs. William C. (Barbara) Tippins, Decatur.

2. That the MAG House of Delegates encourage these fine physicians to remain involved in MAG's tort reform efforts and help lead the way for the passage of other reforms.

**House Action**

Adopted with commendation.

## MAG/GMCF Advisory Committee

**W. Earl Bobo, M.D., Acting Chairman**

This committee was appointed in February, 1983 to "design review proposals and translate the requirements to be imposed by the Federal Government into a specific review process to be administered by the Foundation."

This was at a time when the GMCF and the MAG were experiencing difficulty in negotiating the PRO contract. Other ad hoc committees appointed during that time addressed the various problems and were disbanded. There is no record that this committee ever met.

The current scope of work required by the PRO contractor (GMCF) is very explicit and does not lend itself to someone else translating its requirements. A separate PRO Committee was appointed in 1986. It is directed to educate member physicians regarding the PRO appeals process and actively work with the PRO in providing liaison between the MAG and the PRO (GMCF). In addition, the GMCF Medical Director files a report at each MAG Board meeting.

**Recommendation**

1. That the MAG/GMCF Advisory Committee be officially abolished.

**House Action**

Adopted as amended to read:

*That this committee be officially abolished with the recognition that any Ad Hoc Committee can be reestablished as deemed necessary.*

## Resolution 3

### Penalty For Non-Payment of Tort Reform Assessment

**Bibb County Medical Society**

RESOLVED, that the MAG should seek some means of penalizing MAG members for non-payment of the tort reform assessment *without* reducing our current county delegate entitlements.

**House Action**

Adopted substitute amendment to read as follows:

*"RESOLVED, that the MAG should treat those members who neglected to pay their tort reform dues assessments as delinquent dues paying individuals, and make them subject to all penalties incurred as such."*

## Resolution 4

### Parental Notification of Teen Abortion

RESOLVED, by the Medical Association of Georgia that the Georgia General Assembly be urged not to interfere with the doctor-patient relationship by passing a parental notification requirement in Georgia.

**House Action**

Withdrawn from consideration.

## Resolution 6

### The Medical Effects of Nuclear War

**Medical Association of Atlanta**

RESOLVED, that the Medical Association of Georgia urge its members to better inform themselves and the public of the medical consequences of a nuclear attack; and be it further

RESOLVED, that the Medical Association of Georgia, through its *Newsletter* and *Journal*, disseminate information on the medical consequences of thermonuclear war.

**House Action**

Adopted with commendation.

## Resolution 11

### Teenage Pregnancy

**Ralph A. Tillman, M.D.**

RESOLVED, that the MAG aggressively promote and help finance a statewide program with the primary *objective* to institute educational programs *wherever* necessary, to promote contraceptive aids and instructions and a *goal* to reduce early sexual involvement, unintended, unwanted pregnancies, and sexually transmitted diseases; and be it further

RESOLVED, that the MAG solicit the continuation in these endeavors from A-MAG and certain specialty societies (Georgia OB-GYN Society, Georgia Chapters of the American Academy of Family Practice and Pediatrics and the Georgia Nurses Association.)

*Fiscal Note:* $10,000.

**House Action**

Same as that for Public Relations Committee Report, also considered by Reference Committee A.

## Resolution 16

### AIDS

**DeKalb Medical Society, Inc.**

RESOLVED, that MAG assist in developing and promoting a program designed to reduce the spread of AIDS in Georgia.

**House Action**

Same as that for Public Relations Committee Report, also considered by Reference Committee A.

*Additional amendment introduced on floor of House and referred to the Board of Directors:*

That MAG establish a committee on AIDS by utilizing available expertise to provide input to the Board of Directors, Legislative, Public Health and Public Relations Committees, and to help coordinate the many separate public and governmental efforts in the fight against AIDS.

## Resolution 21

### Prejudice Against Some Medical Patients*

**Cobb County Medical Society**

RESOLVED, that the Medical Association of Georgia affirm its support for the dignity and self-respect of all medical patients; and be it further

RESOLVED, that the MAG affirms that all medical patients should en-


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**Woodridge Hospital,** a 32 bed free standing facility is one hundred per cent dedicated to the treatment of addictive diseases. From intervention to aftercare Woodridge's staff makes our unique natural setting second only to their concern. At **Woodridge Hospital** recovery is a philosophy that demands a way of life. It is lived as well as taught by the staff at **Woodridge.** For the complete story call Dr. Richard Turner, our founder & program director and ask him about *our Alcohol & Drug Treatment or our Eating Disorders Program.*

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joy all the opportunities and privileges for work, education and association consistent with the facts of their medical condition and the basic principles of public health; and be it further

RESOLVED, that the MAG affirms its opposition to all forms of prejudice against any medical patient; and be it further

RESOLVED, that the Medical Association of Georgia, through its delegates seek adoption of the equivalent of this resolution by the American Medical Association House of Delegates.

* Endorsed 3/22/87 by Board of Trustees, Georgia Psychiatric Association.

**House Action**

*Resolve 1:* Adopted.
*Resolve 2:* Adopted.
*Resolve 3:* Adopted as amended to read:
*"RESOLVED, that the MAG affirms its opposition to all forms of* unfounded bias *against any medical patient;*
*Resolve 4:* Adopted.

## Resolution 31

## Marriage License Medical Certification

### Medical Association of Atlanta

RESOLVED, the Medical Association of Georgia declares that current mandatory medical clearance for marriage applicants is unrealistic and unnecessary, but places physicians in a posture of potential liability; and be it further

RESOLVED, the Medical Association of Georgia approach appropriate State governmental bodies for cessation of the requirement for medical clearance of marriage applicants.

**House Action**

Adopted substitute resolution to read as follows:
*"RESOLVED, that the Medical Association of Georgia's Board of Directors review the marriage license certificate to be consistent with the law as currently written.*

## Resolution 32

## Fighting Acquired Immunodeficiency Syndrome in Georgia

### Medical Association of Atlanta

RESOLVED, the Medical Association of Georgia notify the Governor of the State of Georgia that:

1) HIV and AIDS is the most important communicable disease hazard in Georgia.
2) Efforts to fight transmission of this disease do not constitute endorsement of adultery, homosexuality, prostitution, premarital sex or drug abuse.
3) The legislative strength of the Governor is needed and necessary to promote the recommendations of his own Task Force on AIDS.
4) There is an urgent need for State funds to provide direct services, prenatal public health nurses, laboratory testing, Grady Clinic and other AIDS related public health measures.
5) Educational efforts directed at students, adults and health care providers will be the most effective means of slowing the HIV/AIDS epidemic until such time, if ever, that a vaccine is available.

**House Action**

Adopted.

## Resolution 33

## Mandatory Testing for Human Immunodeficiency Virus

### Medical Association of Atlanta

RESOLVED, the Medical Association of Georgia endorses the concept of voluntary testing for human immunodeficiency virus, especially when it is recommended by patient's personal physician; and be it further

RESOLVED, the indications for mandatory, involuntary testing for human immunodeficiency virus are extremely limited and that any mandatory involuntary testing be done only after careful weighing of the benefits and consequences to the patient and society of a positive test result.

**House Action**

Adopted.

## Resolution 48

## Authorization to Evaluate Offers for MAG Headquarters

### Board of Directors

RESOLVED, that the Building and Land Committee be authorized to continue negotiations with the stipulation that any final, acceptable proposal be presented before the Executive Committee or Board of Directors depending upon time frame requirements for final approval.

RESOLVED, that the Building and Land Committee be authorized to spend minimal sums from the Building Reserve Account (currently this fund has $97,992) should architectural consultants, appraisers, real estate attorneys and the like be needed to fully evaluate a purchase offer.

**House Action**

Adopted.

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ZOVIRAX®
(acyclovir)
CAPSULES
Prevent genital herpes recurrences month after month with daily therapy.
(In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.)
Please see last page of this advertisement for brief summary of prescribing information.

# ZOVIRAX®
(acyclovir)
# CAPSULES

## Help free your patients from recurrences.

## Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks —month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

## Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

## Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

*Please see brief summary of prescribing information on next page*

# Prevent recurrences month after month*

# ZOVIRAX® (acyclovir) CAPSULES

Brief Summary

**INDICATIONS AND USAGE:** Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psychosocial difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

**First Episodes** (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

**Recurrent Episodes:**

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

**CONTRAINDICATIONS:** Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

**WARNINGS:** Zovirax Capsules are intended for oral ingestion only.

**PRECAUTIONS: General:** Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

**Drug Interactions:** Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the $F_1$ generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

**Pregnancy:** ***Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS — Short-Term Administration:** The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

**Long-Term Administration:** The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

**DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes:** One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

**Chronic suppressive therapy for recurrent disease:** One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

**Intermittent Therapy:** One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

**Patients With Acute or Chronic Renal Impairment:** One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance $\leq 10$ ml/min/1.73/m$^2$.

**HOW SUPPLIED:** Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200"- Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

Wellcome
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Research Triangle Park
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# REPORT
## Reference Committee
# B

*MUSCOGEE COUNTY GENERAL SURGEON Edmund M. ("Mac") Molnar chaired Reference Committee B.*

*The following physicians served on Reference Committee B: Edmund M. Molnar, Columbus, Chairman; J. Patrick Evans, Savannah, Vice Chairman; William H. Whaley, Atlanta; Charles W. McDowell, Jr., Decatur; L. E. Brown, Macon; Wells Riley, Jonesboro; and Floyd E. Davis, Waycross.*

## Emergency Medical Services Committee

**Rodger Chapman, M.D., Chairman**

Following considerable study and review of pertinent reference documents, the committee presented their final recommendations for a model protocol for handling rape victims in Georgia to the MAG Executive Committee in March, 1987. The guidelines are adopted from the American College of Obstetricians and Gynecologists, published in Technical Bulletin Number 101, dated February, 1987. These protocols reflect a standard of care which should be easily implemented by any facility within the state and which is necessary for adequate and professional treatment of victims o sexual assault. They will assist in the provision of uniform standards and treatment throughout the state and contribute to a high level of professional care.

In conjunction with the medical protocol standards, the Metropolitan Atlanta Crime Commission has completed Rape Guidelines for Law Enforcement which is used by law enforcement agencies in responding to and investigating rape cases. The committee endorsed these guidelines as a useful companion document for effecting a greater degree of consistency in handling

*THE GALLERY OF REFERENCE COMMITTEE B remained interested and active as issues were presented and discussed.*

cases of rape or other sexual assault offenses.

During 1987 and 1988 the committee has selected to examine the issue of resuscitation of the terminally ill patient received in the Hospital Emergency Department. This topic continues to be an issue of strong concern to emergency room practitioners and one deserving careful consideration by a broad spectrum of representatives. Committee recommendations will be considered consistent with prehospital E.M.S. and hospitalwide Do Not Resuscitate policies.

**Recommendation**

1. That MAG recommend consideration of the Sexual Assault Guidelines issued by the American College of Obstetricians and Gynecologists for use by hospital emergency rooms and rape crisis centers throughout Georgia.

**House Action**

Adopted as amended to read:

*"That MAG recommend consideration of the Sexual Assault Guidelines issued by the American College of Obstetricians and Gynecologists, as modified to conform with Georgia laws, for use as a model by hospital emergency rooms and rape crises centers throughout Georgia."*

## Medical Practice Committee

**E. C. Evans, M.D.**

The Medical Practice Committee submits the following report to the House of Delegates for its information and consideration. It discusses:

- DNR Policy Update
- Home Health Services: Trends and Physician Responsibility
- Physician Drug Testing
- AMA Health Policy Agenda for the American People

*DNR Policy Update*

In response to action taken at the 1986 MAG House of Delegates meeting, a request was made to all Georgia hospital Chiefs of Medical Staff and administrators to develop and implement their own Do Not Resuscitate policies. Eight months later, this is a status report of their development in our state: Of the 101 hospitals responding to a survey, a total of 48 hospitals had developed formal guidelines or policies on Do Not Resuscitate; many of these were approved during 1986 and 1987; six hospitals were in the process of developing them; and 49 hospitals still did not have formal policies drafted

in this area. Eighteen of the 49 hospitals were either psychiatric or student health clinics where such policies would be unnecessary, leaving a total of 31 hospitals without having such policies. Many of the surveyed hospitals have asked for the Association's assistance in this area; accordingly, draft policies have been shared with interested facilities.

*Home Health Services: Trends and Physician Responsibility*

The Committee has continued to examine issues related to the delivery and financing of home health care services. A variety of factors — implementation of the Prospective Pricing System (PPS) in October, 1983 forcing shorter hospital stays, the increasing number of elderly, improved home health care technology, and patient preference for in home care has continued the significant growth of this industry. Medicare program figures reveal, for example, that expenditures for home health care increased from $772 million in 1980 to $2 billion in 1985. The number of patient visits nearly doubled, from 23 million to 41 million, during the same period. While representing only 3.1 percent of total expenditures, home health care is now the fastest growing segment of the Medicare budget.

The Georgia State Health Planning Agency recently released in October, 1986, a statewide plan on home health care services in Georgia and revised Certificate of Need rules. The MAG, through representation on a special task force, was able to offer its opinions and direction in this important report.

The Committee pursuits also included strides in clarifying the physician's role in the authorization and responsibility in home health care. Following a request made by the Committee, the U.S. Health Care Financing Administration Regional office prepared and published a federal policy paper, "The Physician's Role in Home Health Services Under Medicare," dated October 24, 1986. This document and other reference materials, as well as speaker representatives, have been made available to interested physicians and/or county medical societies. Meetings with HCFA officials called for a reassertion of concerns similar to those adopted at the AMA 1985 House of Delegates, "that physicians write or carefully review all initial and renewal orders for home health services and approve only those that are medically indicated; that physicians report to appropriate payment agencies and regulatory authorities cases of abusive practices by home health agencies; and that physicians not authorize the provision of home health services to any patient with whom he or she is not professionally involved in providing care." HCFA officials also urged state medical associations to make known their support for the establishing of reimbursement codes for physician services in offered connection with home health care.

In conjunction with the study of home health care services, the committee examined the present role of the physician as assessment team adviser in the Georgia DHR Community Care Program. Passed in 1982, the Community Care for the Elderly Act mandates that any Medicaid recipient or those who would be elgible within 180 days, seeking nursing home placement must be evaluated to determine if community health and social services could meet their needs instead of a long-term care facility. Steps were taken to clarify the physician's role, request revision of the HCFA/DMA-6 form for patient referral, and improve physician involvement in the program at both state and local levels.

*Physician Drug Testing*

During 1986 and 1987 increasing discussion has occurred concerning controversial proposals for widespread drug testing. Requests from facilities for policy guidance, program design and protocols have led to the Committee's examination of this issue, particularly concerning physician drug-testing. National initiatives in drug treatment and testing have added momentum to testing in many spheres of society. The Florida Medical Association introduced a resolution at the AMA 1986 Interim meeting, urging voluntary drug testing by all physicians throughout the country. This was referred to the AMA Board for preparation of a monograph and further study at the April Board meeting. The Committee intends to give ongoing careful attention to this topic and other state and national developments during 1987 after which a policy position will be recommended.

*AMA Health Policy Agenda for the American People*

On February 24, 1987 in Washington, D.C., the Health Policy Agenda was formally released to the American public. A major press conference was held and key Congressional and Administration officials attended. The Health Policy Agenda for the American People (HPA) is an historic effort to provide a comprehensive framework for the development of health care policy in the United States. Representatives of 172 organizations collaborated in this private/public sector initiative to identify and make recommendations on a wide range of health care issues. It contains 195 policy recommendations for all major areas of health care.

The Medical Practice Committee (and I as MAG representative to the HPA Advisory Committee) reviewed the plan and submitted recommendations to the Chairman of the HPA Implementation Committee. The Committee will continue to keep informed on the implementation of the report with timely suggestions, if and when indicated, to the AMA Delegates, MAG Executive Committee or to any others designated by the Executive Committee.

**Recommendations**

1. That the MAG continue to urge Hospital Medical Staffs and admin-

istrators to implement DNR guidelines consistent with their hospital policies and bylaws.

2. That MAG support resolutions relating to the quality of home health care services and reimbursement of the attending physician for treatment of his patient in cooperation with a home health care.

3. That the Medical Practice Committee and MAG continue to monitor implementation of the Health Policy Agenda for the American People and offer appropriate comments of support or concern to the MAG Delegates to AMA or to others designated by the MAG Executive Committee.

**House Action**

Adopted Recommendations 1, 2, and 3.

## Third Party Payors Committee

**C. Peter Lampros, M.D., Chairman**

*Referred to:* Recommendation 1 — Reference Committee C, Recommendation 2 — Reference Committee B.

The Third Party Payors Committee reports the following actions for 1986-87:

*Legislative/Reimbursement Updates*

In an attempt to keep physicians abreast of the latest legislative changes in Medicare and Medicaid, a regular series of informational bulletins have been reported in the "MAG Newsletter" and in direct mailings to the membership. Recent Medicare legislation — the Consolidated Omnibus Reconciliation Act, passed in April, 1986, and a further version, OBRA, passed in October, were analyzed as well as instructions offered on what individual physician actions may be taken to forestall implementation of the law and clarify new provisions. Staff liaisons were strengthened with the Regional Office of the Health Care Financing Administration, the Prudential Intermediary, and the Department of Medical Assistance.

In February, 1987 the MAG, in cooperation with "The Prudential," sponsored a series of four half-day workshops on the basic features of the new Medicare legislation including: the development of reasonable charges, computing the maximum allowable actual charge, the assignment agreement, the claims process, utilization denials and the PRO, the clinical lab, and elective surgery and other program adjustments. A total of some 1000 physicians and/or their medical assistants attended the workshops held in Atlanta and Macon.

*Physician-Sponsored Ambulatory Surgery Centers*

Continuing the work of the Ad Hoc Committee on Office-Based Surgery, actions proceeded to effect changes in the Certificate of Need program and state licensing rules allowing Medicare reimbursement for office-based ambulatory surgical suites. A MAG position paper was written in July, 1986 and distributed to major insurors as well as the completion of a series of meetings with state and federal officials. At the time of this report, a preliminary draft of Certificate of Need Rules has been negotiated allowing CON approval and licensure eligibility for the office-sponsored surgical suite.

*Physician Drug Dispensing*

In December, 1986 the committee was asked by the Department of Medical Assistance to consider the topic of physician dispensing fees for non-sample medications provided in the office setting. The MAG decided to delay taking a position on the topic until further study could be conducted by the committee in 1987.

**Recommendations**

1. That the MAG conduct a careful study of the topic of physician drug dispensing and offer policy guidelines on the ethical, management, and legal considerations involved.

2. That the MAG use its resources to keep physicians informed on the reimbursement changes occurring in Medicare and Medicaid and express strong opposition to those payment system changes which interfere with the efficient and high quality practice of medicine.

**House Action**

Adopted as amended to read:

*"That the MAG continue to use its resources to keep physicians informed on the reimbursement changes occurring in Medicare and Medicaid and express strong opposition to those payment system changes which interfere with the efficient and high quality practice of medicine."*

See Report of Reference Committee C for House Action on Recommendation 1.

## Ad Hoc MAG IPA/HMO Study Committee

**Richard Cohen, M.D., Chairman**

The MAG IPA/HMO Study Committee was established by the House of Delegates last year. The Committee is charged with the responsibility of studying and reporting on the activities and finances of the MAG IPA/HMO. In this regard, the Committee evaluated the progress of the IPA and HMO in accomplishing the goals and objectives implicit in the authorization passed during the 1985 Annual Session.

From a historical perspective, a Special Session of the House of Delegates convened in October 1984 to address MAG's role vis-a-vis the proliferation of Alternative Delivery Systems in Georgia. At that time it was apparent that HMO's were beginning to establish a market base in the state. More importantly, it was apparent other forms of alternative systems — PPO's, indemnity plans with stringent man-

aged care components, and the like — were on the verge of spreading throughout the state as major insurors moved toward offering "triple option" products, i.e., indemnity plan packaged with an HMO and other managed care products such as a PPO.

The question before the House was to what degree MAG should respond to the perceived threats alternative systems placed upon physician's ability to practice quality medical care for the good of Georgia patients. In addressing this question the House considered the financial and administrative resources required under various proposals. And, at length, the House debated the philosophical aspects of such proposals.

All of this debate centered upon prognostications of future developments with the realization that if "one's worst fears materialized" individual physicians would be at the mercy of large insurors and for-profit health chains. I venture to say that few of the Delegates were supportive of the changes adversely impacting traditional modes of medical care delivery. However, it was apparent to the House that some action was required to preserve the quality of care delivered and to insure organized physician input into emerging trends.

As a result of the Special Session, a business plan was introduced at the regular House meeting in April 1985. After lengthy debate the House approved establishment of a MAG sponsored IPA with a separate health insurance component or HMO. Basically, the House approved a plan designed to give physicians a say in the way medical care is delivered in Georgia.

Since that time MAG has developed an IPA, Georgia Physicians Health Network (GPHN), with some 2,500 physician members. Surprisingly, almost 65% of these members are outside the Atlanta area. Also, in January 1986, the Georgia Health System (GHS) — the HMO component — was granted the first state-wide license in Georgia. The HMO is known and marketed as the Georgia Health Network (GHN). Collectively, GPHN and GHS are known as the Georgia Health Network (GHN). For clarity, the terms IPA and HMO will be used in the remainder of this report as appropriate since these are two distinct and separate entities.

It is important to remember that the IPA is the key or "center piece" of MAG's sponsored activities. The IPA is the entity with the greatest potential to meet the goals and objectives implicit in the House's actions. The HMO is merely a conduit for patients and enhances physician input into emerging systems.

The basic tenets of the IPA and HMO can be summarized as follows:

—*Maintenance* of physician input in all professional aspects of medical care delivered to Georgia patients;
—The *provision* of quality medical care to Georgia residents;
—*Opposition* to payment mechanisms which do not provide proper incentives for quality care such as individual physician capitation, overly restrictive gatekeeper systems, and across-the-board fee discounts or discounts disguised as withholds;
—*Preservation* of those aspects of traditional medical practice to which physicians are dedicated within changing market conditions;
—*Establishment* of an organization with wide appeal among physicians that will become the example of contractual principles for all alternative delivery systems.

In the past two years, we have seen growing dissatisfaction among patients and physicians. Some would argue that this will lead to a return to traditional delivery systems. I sincerely *hope* this is the case; however, I fear that we will be involved in more and more changes which may adversely impact your practice. It may well be that HMO's proliferation subsides, but the odds are they will retain a place in the market (10-15%) with PPO's in various nuances, as well as, indemnity insurance under strict managed care arrangements capturing the remainder of the market. These changes could severely impact our ability to practice in the best interest of our patients. Physicians must have a strong voice in the development of acceptable contractual relationships with these plans to assure fair treatment for both the patient and physician.

Since 1985, we have seen alternative systems moving outside of Atlanta and spreading throughout the state. For example, the Blue Cross VIP program is an alternative delivery system (a PPO specifically) impacting most of the state. Additionally, Blue Cross is marketing its captive "HMO Georgia." In the next twelve months, we expect most major insurance carriers to offer PPO's and other forms of managed care on a state-wide basis.

We have seen carriers offer contracts to physicians with across-the-board fee *discounts*. We have watched "withholds" become discounts and physicians lose faith in promises that withheld fees will be repaid. We have witnessed hospitals propose PPO's allowing participation by only a small portion of physicians on staff.

We have seen physician fees capped at ever decreasing percentile levels. We expect more HMO's to move to physician capitation and to tighten utilization review criteria which could adversely affect the quality of medical care. We have heard more and more talk of the use of "gatekeeper" systems to restrict freedom of patient choice.

In short, the fears which led to the House's action in 1985 have materialized and will continue to become more and more prevalent. MAG's IPA is postured to help maintain physician control in critical areas of medical practice. As you will see in the remainder of this report, Georgia Physicians Health Network (the IPA or GPHN) activi-

ties — beyond its relationship with MAG's captive HMO, Georgia Health System (GHS) — have not been easy and in some respects, could not be termed an "overnight" success on paper. However, it is my belief that the IPA is on the verge of taking steps toward accomplishing its goal of protecting those aspects of medical practice to which Georgia physicians are dedicated.

*SERVING ON REFERENCE COMMITTEE B are (L to R) J. Patrick Evans, Vice-Chairman, from Georgia Medical; Ronald P. Roper, of Cobb; Charles W. McDowell, Jr., of DeKalb; and L. E. Brown, from Bibb.*

*IPA Activities*

In retrospect, enough emphasis was not placed on educating our membership of the potential activities of the IPA. Many continue to see the HMO as MAG's thrust in the area of medical-economics. The fact is, the IPA is the "future" to fulfilling the goals and objectives expressed earlier in this report.

This fact can be illustrated by looking at a few events which have transpired in the past year. Probably the most important success to date of the IPA's ability to negotiate is in the area of *CHAMPUS Reform.* Last May we heard the first rumors of Department of Defense plans to reorganize the delivery of private health care to some 5,000,000 military retirees, dependents and those on active duty. While many felt Congress would never approve such a plan, MAG's IPA became involved very early to insure, once again, that physicians have a say in the way health care is delivered should this project move forward.

In fact, MAG's President, John D. Watson, Jr., M.D., was instrumental in establishing the Alliance of State Physician Networks, a proactive organization to educate state medical associations in preparation for the coming CHAMPUS Reform. The Alliance is comprised of some 30 states who have joined or participated in activities. Dr. Watson's vision is that CHAMPUS Reform will be the model for future reorganization of other government health plans such as Medicare. His belief is that physicians must be involved at the outset to insure input in future developments which will affect a significant portion of our medical practice.

In September 1986, Congress approved a phased implementation of the CHAMPUS Reform Initiative. Over a three year implementation period, CHAMPUS Reform will call for government payment to the successful bidder for CHAMPUS beneficiaries. The successful bidder will probably be a combination of large insurance companies, fiscal intermediaries and physician groups. The successful bidder will have the ability to establish reimbursement methodologies and utilization management programs to assure health care costs are within limits of government payments.

It is not difficult to envision how these aspects will develop without organized physician input. From a physician's viewpoint, many bidders for the CHAMPUS contract will propose across-the-board fee discounts and utilization controls generally unacceptable to patients as well as physicians. Many bidders will accomplish this by establishing their own networks, contracting with physicians individually.

MAG's sponsored IPA has reached a tentative agreement with a key bidder in Georgia and Florida — EQUICOR, a joint venture between the Equitable Assurance Company and HCA. This agreement provides the proper incentives for the delivery of quality care within the constraints imposed by the Department of Defense and endorsed by Congress.

The agreement negotiated by the IPA stipulates that individual capitation payments to physicians, gatekeepers and across-the-board fee discounts are *not* acceptable contractual terms. The IPA's leadership believes these type arrangements do not offer proper incentives for quality patient care under CHAMPUS Reform.

Briefly, this agreement insures that physicians will control utilization review criteria and professional credentialing. Also physicians will be reimbursed under a unique withhold system where physicians will receive 100% of their fee, subject to reasonable fee maximums, if utilization goals are met. This arrangement is infinitely better than across-the-board discounts or individual capitation promoted by most bidders.

The IPA leadership believes this arrangement accomplishes the goals implicit in the action of MAG's House of Delegates. The leadership fully realizes that the IPA will have to thoroughly apply proven utilization techniques to meet CHAMPUS requirements and that application of these methods may cause dissatisfaction among a relatively small percentage of members. However, if we are not successful, physicians

will lose an important element of control essential to the delivery of quality medical care in the future.

Another example of IPA activities has occurred in the past few months. Recently, I have witnessed renewed interest in MAG's activities among Cobb and Fulton County physicians. This interest is a result of problems encountered by physicians contracting with several HMO's in Atlanta — Ameriplan, Health First and CIGNA specifically. Until recently, many considered these HMO's somewhat physician friendly. Unfortunately, market conditions and ownership have changed to the point that we now see fees being reduced; proposals of physicians capitation; complete loss of fees withheld; and contract and fee arrangements modified unilaterally without physician consultation or notification.

Many physicians in Cobb and Fulton Counties now see the need for an organization capable of providing an "umbrella" to negotiate fair terms for physicians and their patients. While MAG's sponsored IPA is still maturing, I believe the IPA offers the potential to negotiate for its members in much broader ways than many previously envisioned.

Additionally, the IPA's panel of physicians is in a position to contract with hospitals and other groups planning PPO type arrangements. In fact, MAG's sponsored IPA is the panel for a PPO established by Phoebe Putney Hospital in Albany currently having approximately 11,500 patients enrolled. Again, the IPA was able to assure acceptable terms for these local physicians.

These type IPA activities could expand rapidly in the next twelve months as PPO's and HMO's scramble for survival and large indemnity insurors increase their efforts in meeting market demands for alternative systems. I believe we will see an increasing number of physicians turning to the IPA for help in meeting the challenges of the changing market place.

In March, the IPA Executive Committee approved paying all the physician fees withheld during the first year of operation. This reinforces my belief that as long as IPA activities are guided by the best interest of physicians and their patients, the goals of the House of Delegates will be accomplished and we will preserve quality medical care in the state.

*HMO Activities*

In reviewing the accomplishments of the Georgia Health System, the HMO component, it is evident that much has been accomplished; but it is also apparent that efforts must be redoubled to meet important goals. The HMO moved rapidly to meet licensure requirements of the State Insurance Department. The HMO developed administrative structures for day-to-day utilization review, finance, data processing and the like. All of this was put together in a short six month period to prepare for licensure inspection.

On the other hand, marketing efforts have not met their projections. This January, marketing activities were completely restructured including hiring an experienced HMO marketing director. In the Macon area some 2,000 enrollees have been signed and the HMO is now moving to achieve this level of success in other areas of the state. An agreement providing a state-wide brokerage network to enhance marketing efforts is currently being implemented.

If the HMO is to meet its goals, it must continue to expand its efforts in the next six months. It is important to remember that the HMO is only one component of the project passed by the House. As explained earlier the IPA is the centerpiece of the project. The HMO enhances IPA activities and establishes an HMO model for employers and physicians to use as a benchmark when assessing various alternatives.

MAG's sponsored HMO is owned and controlled by physicians, and is to my knowledge, the only such organization in Georgia acting solely in the interest of physicians and patients. As an example, last fall the HMO was reviewed and accepted by Bell South to be the only HMO offered to some 18,000 employees outside the Atlanta area. Bell South performed an extensive review of systems, physicians and organizational structured in granting this approval. There is little question that this account would have been a tremendous asset to marketing efforts.

Unfortunately, the premium structure offered by Bell South would have also *guaranteed* that funds withheld from physician fees would become in effect a discount of approximately 20%. This structure was unacceptable because it would have violated the basic tenets governing the IPA and HMO activities. Accordingly, the HMO Board declined to offer its plan to Bell South employees. This was a marketing disappointment, but re-emphasized the commitment to Georgia physicians.

*Financial Results*

From the outset, it has been obvious to this Committee that the financial aspects of these activities have proven difficult to communicate to the membership. All financial aspects concerning the IPA and HMO have been available through MAG's Annual Audit, reports to the Board and House; the "Proceedings" issue of *JMAG;* and financial reports by GHN.

However, it is clear that these reports have been extremely complicated considering the number and complexity of the entities involved. Notwithstanding these past communication problems, this Committee would like to present a concise picture of financial transactions to insure membership understanding of what has transpired during the past two years. The report on the following page summarizes financial transactions within MAG.

*Activities Within MAG*

| | | |
|---|---|---|
| Receipts of Dues Assessments for Medical Economic Activity June 1985-December 1985 | | $2,506,000 |
| Expenditures by MAG for consulting, legal, and educational activities October 1984-February 1986: | | |
| Salaries & Benefits | $132,000 | |
| Legal Fees | 181,000 | |
| Travel | 11,000 | |
| Telephone, printing, office | 57,000 | |
| Consulting | 163,000 | |
| Data Processing | 109,000 | |
| TOTAL MAG EXPENDITURES | | ($ 653,000)[1] |
| Voting stock purchased by MAG in GHN | | ($ 650,000)[2] |
| Excess Receipts over Disbursements | | $1,203,000 |

[1] The $653,000 delineated above were expenditures by MAG to educate the membership and to perform feasibility studies leading to implementatioin of the IPA and its component HMO. It includes a fair allocation of *all* MAG staff time expended on this project. Beginning March 1, 1986, all expenditures relating to these activities became the responsibility of the IPA and HMO. MAG continues to write checks off its accounting system; however, the IPA and HMO reimburses MAG for such disbursements, as well, as an administrative fee for management services. The $653,000 includes all direct and indirect expenditures chargeable to medical economic activities. Therefore, *no* MAG dues monies have been used to fund this project. Thus, MAG was repaid with interest for staff time allocated to the project as well as the cost of the Special Session in October 1984.

[2] $500,000 of this represents a line of credit to GHN as required by the State Insurance Commissioner.

As explained on the preceding page, on March 1, 1986, the IPA and HMO assumed total financial responsibility. Financial results of the IPA and HMO are summarized as follows:

| | |
|---|---|
| Receipts from non-voting preferred stock purchased by physicians | $1,052,000 |
| Receipts from voting stock purchased by MAG | $ 650,000 |
| TOTAL CAPITAL RAISED | $1,702,000 |
| Expenditures net of interest and earnings on premiums through March 31, 1987 | ($ 651,000) |
| Equity balance as of March 31, 1987 | $1,051,000 |

It is sufficient to say that the HMO's marketing efforts must improve significantly during the next six months. At this time, monthly administrative expenditures average approximately $60,000. Current projections, based upon enhanced marketing efforts, are for break-even by early 1988 at a patient enrollment level of approximately 13,000. It is critical for the long term viability of the HMO that this level be achieved. However, one should realize that the success of the IPA, as indicated earlier, is not necessarily tied directly to the HMO.

As Committee Chairman, I sincerely hope this summary has adequately delineated financial transactions during the past two years. After careful review, this Committee is satisfied that all financial transactions have been appropriate and consistent with the language and intent of the original House of Delegates action in April, 1985.

*Report Summary*

We are witnessing the maturation of a system developed to give physicians a say in the way health care is delivered consistent with the House of Delegates actions in 1985. In this respect, it is appropriate to re-state the contracting principles which govern these activities:

—The IPA and HMO will OPPOSE individual physician capitation reimbursement systems; they inject incentives into the medical care system that are prejudicial to high quality patient care;

—The IPA and HMO will OPPOSE "gatekeeper" systems of case management; they too inject incentives that are prejudicial to high quality care, and impose undue financial risks on primary care physicians;

—The IPA and HMO will OPPOSE straight percentage fee discounts; they penalize the efficient, low-cost physician even more severely than the high-cost physician who is supposedly the target of these types of "controls" and do not offer proper utilization control incentives;

—The IPA and HMO will SUPPORT reasonable ceilings on fees to meet competitive market place forces, while adequately compensating physicians;

—The IPA and HMO will SUPPORT risk/incentive systems that provide for the return of monies held "at risk" if reasonably attainable cost-control criteria are met by the physician group;

—The IPA and HMO will INSIST that professional aspects of the practice of medicine (such as credentialing, quality assurance, utilization review, retrospective peer review and professional discipline) be controlled by our bona fide professional peers.

In concluding, your Committee is satisfied that although some mistakes have been made, they have not been in an effort to deceive. We have openly identified problems, allowed clear discussions and set upon a new course. One can anticipate greater progress in the coming years as the Organization continues to mature.

Members of the MAG Ad Hoc IPA/HMO Study Committee are: Richard W. Cohen, M.D., Chairman; Lanny R. Copeland, M.D.; Cyler D. Garner, M.D.; Bannester L. Harbin, M.D.; Charles A. Lanford, M.D.; Charles McDowell, Jr., M.D.; William W. Moore, Jr., M.D.; L. Newton Turk, III, M.D.

**House Action**

Filed with commendation.

*OTHER MEMBERS OF REFERENCE COMMITTEE B are (L to R) Wells Riley, of Clayton-Fayette; William H. Whaley, of the Medical Association of Atlanta; and Floyd E. Davis; of Ware.*

## Ad Hoc Committee on Primary Care

**James Van Buren, M.D., Chairman**

The Ad Hoc Committee on Primary Care was appointed to review and provide input on primary care participation within the Georgia Health Network (GHN).

In fulfilling this charge, the Committee developed a questionnaire for primary care physicians — Family Practice, General Practice, Internal Medicine and Pediatrics — in the Macon and Warner Robins area to evaluate their concerns regarding GHN. Additionally, the Committee sought the advice of appropriate specialty societies and other groups interested in primary care as it relates to alternative delivery systems.

It is the Committee's conclusion that the primary care specialties are *essential* to the provision of quality health care to Georgians. Alternative Delivery Systems, and in particular GHN, must have vigorous support by physicians in these specialties. No alternative system can survive and insure the delivery of quality care within competitive cost constraints without such support.

Specifically, the Ad Hoc Committee on Primary Care submits the following recommendations:

### Recommendations

1. In reviewing the composition of the GHN Board of Directors and its various committees, we were struck by the scarcity of primary care physicians and would, therefore, recommend that the specialty composition of GHN's Board and Committee be proportionate to the membership of MAG.

2. Uniform withholding of fees for risk pools among all specialties is prejudicial against primary care physicians considering the increased risk and overhead costs inherent in the practice of primary care. The Committee recommends that a variable withhold percentage be developed to eliminate this disparity among specialties.

3. The Committee identified some discrepancies in GHN's marketing literature and activities. Based upon this analysis, it is recommended that marketing information be vigorously reviewed to insure accuracy.

4. It is recommended that MAG monitor developments in corporate and contracted medicine in the state. Results should be regularly disseminated to the membership through a mechanism such as an "economic page" in the *Journal of the Medical Association of Georgia* along with other pertinent information.

As Chairman, I would like to thank the members of the Committee for their diligent efforts. Should the House of Delegates approve our recommendations, we have achieved our Committee charge and would recommend this Committee be dissolved.

### House Action

Recommendation 1 was not adopted.

Recommendation 2 was not adopted.

Recommendation 3 was adopted as amended to read:

*"It is recommended that GHN marketing information be carefully reviewed to insure accuracy."*

Recommendation 4 was adopted as amended to read:

*"It is recommended that MAG monitor developments in corporate and contracted medicine in the state and the results be regularly disseminated to the membership."*

Recommendation 5 was adopted by substitution:

*"The Ad Hoc Committee on Primary Care be continued for the following year and report at the next annual session of the MAG House of Delegates."*

## Ad Hoc Committee on PRO Review

**Sammie Dixon, M.D., Chairman**

As a result of 1986 MAG House of Delegates action relating to the GMCF/PRO, this committee was appointed "to educate physicians regarding the PRO appeals process and actively work with the PRO in providing liaison between the MAG and the PRO.

"Further, the committee is directed to give quarterly reports on the status of denials and PRO activities to the MAG Board of Directors."

Due to the delay in the HCFA/GMCF negotiation of the 86-88 contract, its requirements were not fully

implemented until the first quarter of 1987 — so the committee has had very little to report to date. The GMCF Medical Director routinely reports GMCF/PRO activities to the MAG Board of Directors.

*Background*

The PRO must perform the following functions:

1) review of the reasonableness, necessity, and appropriateness of hospital admissions;
2) review of completeness, adequacy and quality of care provided;
3) validation of diagnoses and procedural information which determine Medicare reimbursement;
4) review of the necessity and appropriateness for which payment is being sought on an "outlier" basis.

*Review Process*

Cases to be reviewed include:

1) those identified by quarterly profiling as "aberrant" providers, practitioners, DRGs, etc.;
2) 3% random sample from fiscal intermediary data;
3) provider-specific data on outcome outliers furnished by HCFA;
4) DRG specific data on outcome outliers furnished by HCFA;
5) other outliers identified by HCFA/PRO;
6) readmission within 15 days of discharge;
7) transfers;
8) hospital notice of non-coverage;
9) cases referred by fiscal intermediary;
10) cases with non-covered admission during which some level of covered care was provided;
11) specialty hospital review;
12) percutaneous lithotripsy review;
13) preadmission review;
14) other problems that may be identified by the PRO or HCFA.

The following activities must be performed on all cases selected for review and appropriate intervention must be initiated:

1) coverage review;
2) admission review;
3) DRG validation;
4) generic quality screens;
5) discharge review — emphasis is being placed on possible premature discharge.

The GMCF has in the past, and is continuing the review process directed toward utilization review and education. Each PRO is required to achieve specific objectives directed toward elimination of adverse outcomes (including premature discharges) and reduction of unnecessary admission and/or procedures by focusing on providers and/or practitioners and specific DRGs.

For each objective, the PRO must implement certain interventions. These interventions must include, but not be limited to, denials (if appropriate) education, intensified review and sanction. Emphasis is being placed on quality of care review and the sanction process.

There are no numerical quotas involved in the GMCF/PRO review process. Specific objectives included in the GMCF contract indicate that 19 hospitals, 63 physicians and 20 DRGs are under intensified review — intensified review ranges from monthly profiling to 100% review, depending on the severity level involved.

Before recommending a sanction, the PRO must determine that the provider/practitioner has: 1) substantially violated an obligation in a substantial number of cases; or 2) grossly and flagrantly violated an obligation in one or more cases. A substantial violation in a substantial number of cases is a pattern of care which has been provided that is inappropriate, unnecessary, or does not meet recognized professional standards of care, *or is not supported by the necessary documentation of care as required by the PRO.* A gross and flagrant violation is a violation of an obligation which has occurred in one or more instances and which presents an imminent danger to the health, safety, and well being of a Medicare beneficiary or unnecessarily places the beneficiary in high risk situations such as risk of substantial and permanent harm.

An obligation is defined as follows:

Each provider/practitioner must assure to the extent of his authority that services ordered or provided:

1) will be provided economically and only when, and to the extent, medically necessary;
2) will be of a quality which meets professionally recognized standards of health care; and
3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

*Appeal Mechanisms*

The GMCF has two review/appeals processes: 1) GMCF Reconsideration, which affords the patient, physician, and/or hospital the right to request reconsideration of any adverse determination. This request must be submitted in writing within 60 days after receipt of a denial notice, except reconsideration of a preadmission denial is expedited by requiring response within three working days. 2) Quality Intervention Program. Beginning August, 1987, the Medicare Review System under the Professional Review Organization (PRO) program includes a review of the quality of care. The Georgia Medical Care Foundation (GMCF), the PRO contractor for Georgia, has developed a plan approved by subjecting the cases to multiple levels of review. The plan gives physicians and hospitals opportunities to respond when quality problems are cited. Before any serious action is taken, physicians are given an opportunity

to meet with the GMCF review committee and discuss each case questioned.

When in the process of reviewing cases and a quality issue is raised by a PRO Physician Advisor, a Quality Review Notification form is sent to both the physician and the hospital. The form indicates the quality problem being cited by the PRO Physician Reviewer and describes the opportunity and the time frames the attending physician and the hospital have to respond. After the allotted time, the case is reviewed a second time using the additional documentation if any is submitted. Upon final determination, a letter is issued to notify the physician and the hospital of the outcome.

The Quality Intervention Plan contains five (5) levels with the fifth being the most serious quality problem. Each severity level contains three (3) classes and each class has a threshold number of cases except for level 5.

With the final determination of a severity level 1-5 the threshold count begins for the specified level. As the threshold number of cases is met in severity levels 1-4 for Class II Interventions, the physician or provider is notified that the threshhold has been reached and of the opportunity to submit additional information and to meet or participate in a teleconference with a subcommittee of the Medical Review Committee. The physician/provider will be notified of the interventions which will be implemented as a result of the determination of the subcommittee.

If after review by members of the physician's specialty, a quality problem does exist, educational efforts are undertaken and corrective action plans are set up. If the problem is not corrected, and as a last resort, sanctions are recommended to the HHS office of Inspector General.

As the threshold number of cases is met for Class III, the cases are reviewed by the Medical Review Committee and the first sanction notice is issued after validation of the quality issues by the committee.

Severity level 5 contains one class which is the initiation of the first sanction notice after the determination is made that the case represents a level 5 quality of care and after validation by the Medical Review Committee.

If you are interested in receiving more detailed information about the Quality Review Process, you can call 1-800-282-2614 or 982-6500 and request the information, or write GMCF, PRO Department, 4 Executive Park Drive, NE, Suite 1300, Atlanta, Georgia 30329.

If you would be interested in reviewing Medicare Cases for quality issues, please contact the GMCF. Your assistance is welcomed and needed.

The flow charts attached show the steps in the process. Exhibit I shows the Initial Review Process, Exhibit II, the Quality Intervention Plan Process and Exhibit III, the Sanction process. *(Editorial Note: These charts are available on request at MAG.*

To our knowledge, the GMCF goes far beyond the expectations — probably the desires — of HCFA in the extensive involvement of physicians in number, specialty and geographic location in its review system.

**Recommendations**

1) That the MAG PRO Review Committee continue for at least one year to keep physicians advised of new and/or changing developments and to work with both physicians and the PRO to help correct problems as they arise.
2) That the GMCF/PRO Medical Director continue to report pertinent activities to the MAG Board of Directors.
3) That interested, actively practicing physicians be urged to volunteer to serve in the GMCF/PRO ongoing review/appellate process, subject to its credentialing procedures.

**House Action**

*Recommendation 1:* Adopted as amended:

*"That the MAG PRO Review Committee continue to keep physicians advised of new and/or changing developments and to work with both physicians and the PRO to help correct problems as they arise."*

*Recommendation 2:* Adopted as amended:

*"That the GMCF/PRO continue to report pertinent activities to the MAG Board of Directors."*

*Recommendation 3:* Adopted.

## Resolution 5

## Funding of Family Planning Program

### Medical Association of Atlanta

RESOLVED, by the Medical Association of Georgia that the Georgia General Assembly be strongly encouraged to fund the family planning program adequately to meet the needs of the residents of this state.

**House Action**

Adopted as amended to read:

*"RESOLVED, by the Medical Association of Georgia that the Georgia General Assembly be strongly encouraged to fund the family planning program at or above current levels."*

## *Resolution 12*

## Alternative Health Care Delivery Systems

### Ralph A. Tillman, M.D.

RESOLVED, that the House of Delegates of MAG vigorously oppose any legislation that would tend to promote or promulgate any system of pre-paid health care delivery as being favored by the MAG over traditional private practice which encompasses a very large percentage of physicians in this state who choose to practice without the en-

cumbrances imposed by all of the AHC systems.

**House Action**

Adopted as amended to read:

*"That the House of Delegates of MAG vigorously oppose any legislation that would give alternative health care delivery systems statutory advantage over the traditional private practice of medicine."*

## *Resolution 14*

## Marketing of Georgia Health Network

**Glynn County Medical Society**

RESOLVED, that the Georgia Health Network and officers be directed not to market its product in areas where there is no established HMO and/or a majority of the members of a component medical society have voted that the Georgia Health Network HMO PPO not be marketed; and be it further

RESOLVED, that the Georgia Health Network and officers be directed to make provision in any of its statewide contracts for an exclusion to be made for areas where there is no HMO and/or a majority of the members of a component medical society have voted that no marketing be done.

**House Action**

Recommendations 1 and 2 were not adopted.

## Resolution 17

## Physician Reimbursement in Home Health Care Managaement

**E. C. Evans, M.D.**

RESOLVED, that MAG encourage AMA to develop without delay a coding mechanism for physician services to Home Health Care patients.

**House Action**

Adopted as amended to read:

*"RESOLVED, that MAG encourage AMA to develop without delay a method (such as a CPT Code) identifying services for reimbursement of physicians who are managing the care of home bound patients through a home health care agency."*

## Resolution 18

## Quality Assurance in Home Health Care

**E. C. Evans, M.D.**

RESOLVED, that MAG seek appropriate methods to influence the policy-making groups in Georgia relating to Home Health Care; and be it further

RESOLVED, that AMA be encouraged to seek appropriate methods to influence the policy-making groups relating to Home Health Care at the national level; and be it further

RESOLVED, that MAG encourage AMA to support, or possibly initiate, good legislation for peer review of Home Health Care Services with physician involvement in the review.

**House Action**

*Recommendation 1:* Adopted.

*Recommendation 2:* Adopted.

*Recommendation 3:* Adopted as amended:

*"RESOLVED, that MAG encourage AMA to develop or support effective methods for quality assurance in home health care."*

## Resolution 19

## IPA/HMO (GHN)

**Dougherty County Medical Society**

RESOLVED, that the IPA and the HMO (GHN) present a financial statement to this 1987 House of Delegates which includes, but not limited to, all sources and amounts of revenue and all expenditures (identified) since inception and a statement of assets and liabilities to date; and be it further

RESOLVED, that the IPA/HMO (GHN) discontinue operation by the effecting of a merger with an appropriate health care organization with enrollment available to MAG members without a mandatory fee or stock purchase requirement.

**House Action**

Not adopted.

## Resolution 20

## Patient Rights Under Health Insurance

**George L. Smith, M.D.**

RESOLVED, that MAG support legislation protecting patient rights by limiting an insuror's ability to alter contracts with physician and/or patients without appropriate safeguards to preserve the quality of care delivered.

**House Action**

Referred to MAG Board of Directors.

## Resolution 38

## Position on Profits from Withholding Care

**DeKalb Medical Society, Inc.**

RESOLVED, that the Medical Association of Georgia not become involved in any medical care system in which the physician profits from withholding care from patients; and be it further

RESOLVED, that this be established as an official MAG position.

**House Action**

*Recommendation 1:* Adopted as amended to read:

*"That the Medical Association of Georgia not become involved in any medical care system in which the physician profits from withholding necessary care from patients."*

*Recommendation 2:* Not adopted.

## Resolution 39

### Georgia Health Network

**DeKalb Medical Society, In.**

RESOLVED, that the House of Delegates authorize an independent audit of the Georgia Health Network; and be it further

RESOLVED, that the results of this audit be presented to the MAG Executive Committee and Board of Directors immediately in order to determine if the program should be continued.

**House Action**

*Recommendation 1:* Not adopted.
*Recommendation 2:* Not adopted.

## Resolution 40

### MAG's IPA and its HMO

**F. William Dowda, M.D.**

RESOLVED, that the MAG assess its membership two million dollars (to make the ultimate success of our effort a certainty) to be used for operating capital and reserves for our insurance — panel effort.

**House Action**

Referred to MAG Board of Directors.

## Resolution 44

### Job Action

**F. William Dowda, M.D.**

RESOLVED, that the MAG hire consultants to help us develop options for job actions including a study as to why Doctor Strikes in the past have been unsuccessful and what alternatives for self defense are available and might feasibly work.

**House Action**

Referred to MAG Board of Directors.

## Resolution 45

### Capitation

**Ralph A. Tillman, M.D.**

RESOLVED, that while recognizing the rights of any practicing physician to enter into contractual arrangements with any alternative health care delivery system, he/she deems desirable and necessary, the House of Delegates of MAG recommends the development of a policy statement strongly opposing capitation as a means of remuneration for health care services; and, Be It Further

RESOLVED, that MAG delegates to the AMA be instructed to promote the development of a similar policy for the AMA.

**House Action**

*Recommendation 1:* Adopted as amended to read:

*"That while recognizing the rights of a practicing physician to enter into contractual arrangements with any alternative health care delivery system he/she deems desirable and necessary, as a matter of policy the House of Delegates of MAG opposes individual physician capitation reimbursement systems.*

*Recommendation 2:* Adopted.

## Resolution 46

### Mandatory Enrollment in HMOs

**Ralph A. Tillman, M.D.**

RESOLVED, that the House of Delegates of MAG go on record as opposing mandatory HMO enrollment; and be it further

RESOLVED, that efforts be made through whatever means necessary to seek an amendment to the Federal law stipulating that HMO's not be the only health care plan available to employees.

**House Action**

Recommendations 1 and 2 adopted.

## Resolution 47

### Georgia Health Network

**MAG Executive Committee**

NOW THEREFORE, be it RESOLVED that Georgia Health Network is herewith directed to pursue negotiations looking to a merger, joint venture, or joint marketing efforts with other appropriate health care organizations, so that multiple products and additional marketing skills and resources are available to meet the current requirements for success; and be it further

RESOLVED, that any such relationship shall be consistent with the original goals and intent of the 1984 Special Session and the 1985 MAG House of Delegates.

**House Action:**

*Recommendation 1:* Adodpted as amended to read:

*"That Georgia Network is herewith directed to pursue negotiations looking to a merger, joint venture, or joint marketing efforts with other appropriate health care organizations, so that multiple products and additional marketing skills and resources are available to meet the current requirements for success; and consider other business decisions such as the exchange or repurchase of MAG stock back to the Georgia Health Network."*

*Recommendation 2:* Adopted.

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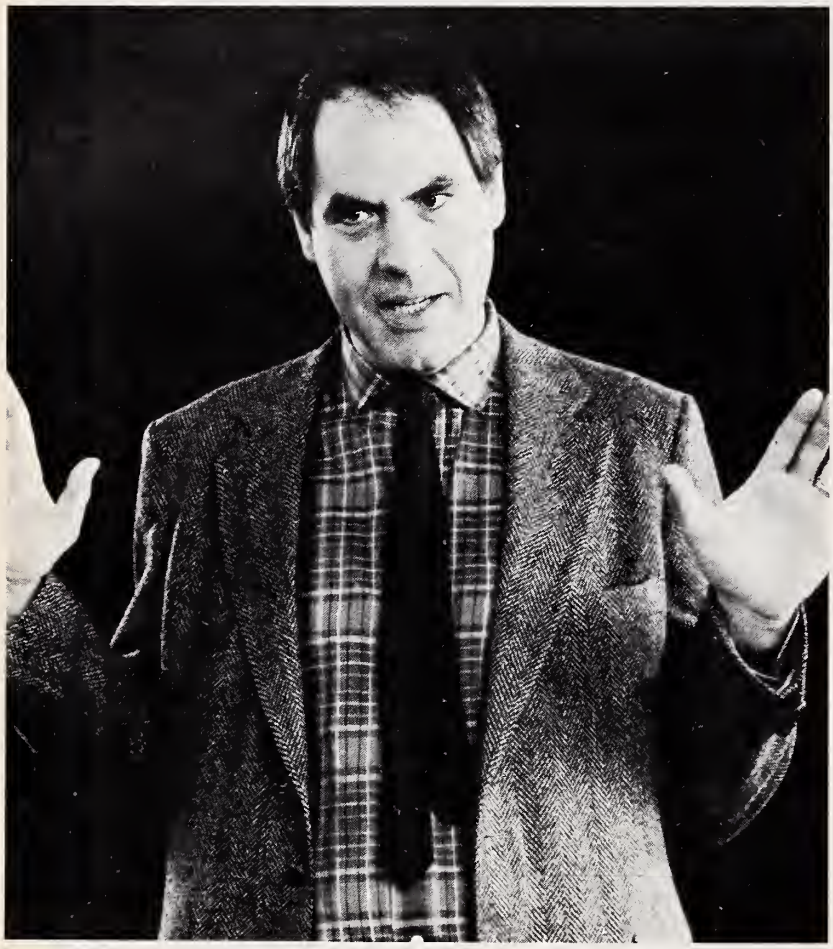

Robert Klein

# TAKE CARE OF YOUR LUNGS. THEY'RE ONLY HUMAN.

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ZANTAC® 150 h.s.

ranitidine HCl/Glaxo 150 mg tablets

EFFECTIVE MAINTENANCE THERAPY

for healed duodenal ulcer patients

See last page for references and
Brief Summary of Product Information.

Glaxo/ROCHE

CONFIRMED

In two randomized, double-blind, and well-controlled clinical trials, ZANTAC 150 mg h.s. significantly superior to cimetidine 400 mg h.s. for maintenance therapy in healed duodenal ulcers.

Percent of patients with observed duodenal ulcer recurrence

| | | 0-4 months | 0-8 months | 0-12 months | No. patients |
|---|---|---|---|---|---|
| USA[1] | ranitidine 150 mg h.s. | 9% | 14%* | 16%† | 60 |
| | cimetidine 400 mg h.s. | 23% | 34% | 43% | 66 |
| UK, Ireland, Australia[2] | ranitidine 150 mg h.s. | 8%‡ | 14%‡ | 23%‡ | 243 |
| | cimetidine 400 mg h.s. | 21% | 34% | 37% | 241 |

*p=0.02
†p=0.01
‡p≤0.004
%=life-table estimates
All patients were permitted prn antacids for relief of pain.

These two trials used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comparison of other dosing regimens has not been studied.

The studied dosing regimens are not equivalent with respect to the degree and duration of acid suppression or suppression of nocturnal acid.

The superiority of ranitidine over cimetidine in these trials indicates that the dosing regimen currently recommended for cimetidine is less likely to be as successful in maintenance therapy.

Convenient once-a-night dose with a

low incidence of side effects[3]

Headache, sometimes severe, seems to be related to ranitidine administration. Other side effects have been reported; for a complete listing, see the **ADVERSE REACTIONS** section in the Brief Summary.

No significant interference with the hepatic cytochrome

P-450 enzyme system at recommended doses

ZANTAC 150 mg has no significant drug interactions with theophylline, phenytoin, or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH may be altered when ZANTAC or other medications that decrease gastric acidity are administered.

**Zantac® 150**

*ranitidine HCl/Glaxo 150 mg tablets*

One tablet at bedtime
for maintenance

See next page for references and
Brief Summary of Product Information.

Glaxo/ROCHE®

CONFIRMED

# Zantac® 150

ranitidine HCl/Glaxo 150 mg tablets

## *One tablet at bedtime for maintenance therapy in healed duodenal ulcer patients*


**References:**

1. Silvis SE, Griffin J, Hardin R, et al: Final report on the United States multicenter trial comparing ranitidine to cimetidine as maintenance therapy following healing of duodenal ulcer. *J Clin Gastroenterol* 1985;7(6):482-487.
2. Gough KR, Korman MG, Bardhan KD, et al: Ranitidine and cimetidine in prevention of duodenal ulcer relapse: A double-blind, randomised, multicentre, comparative trial. *Lancet* 1984;ii:659-662.
3. Data available on request, Glaxo Inc.


**ZANTAC® 150 Tablets**
**(ranitidine hydrochloride)**
**ZANTAC® 300 Tablets**
**(ranitidine hydrochloride)**

**BRIEF SUMMARY OF PRODUCT INFORMATION**

The following is a brief summary only. Before prescribing, see complete prescribing information in ZANTAC® product labeling.

**INDICATIONS AND USAGE:** ZANTAC® is indicated in:

1. Short-term treatment of **active duodenal ulcer.** Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within one or two weeks after starting therapy and is maintained throughout a six-week course of therapy.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

**CONTRAINDICATIONS:** ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

**PRECAUTIONS:** Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy.

Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSAGE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Although recommended doses of ZANTAC do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Lack of experience to date precludes recommending ZANTAC for use in children or pregnant patients. Since ZANTAC is secreted in human milk, caution should be exercised when administered to a nursing mother.

**ADVERSE REACTIONS:** Headache, sometimes severe, seems to be related to ZANTAC® administration. Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

There have been rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

**OVERDOSAGE:** Information concerning possible overdosage and its treatment appears in the full prescribing information.

**DOSAGE AND ADMINISTRATION. Active Duodenal Ulcer:** The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

**Maintenance Therapy:** The current recommended adult oral dosage is 150 mg at bedtime.

**Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome):** The current recommended adult oral dosage is 150 mg twice a day. In some patients it may be necessary to administer ZANTAC 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

**Benign Gastric Ulcer:** The current recommended adult oral dosage is 150 mg twice a day.

**GERD:** The current recommended adult oral dosage is 150 mg twice a day.

**Dosage Adjustment for Patients with Impaired Renal Function:** On the basis of experience with a group of subjects with severely impaired renal function treated with ZANTAC, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

**HOW SUPPLIED:** ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

**Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.**


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**Glaxo**

Glaxo Inc.
Research Triangle Park, NC 27709

# REPORT
# eference Committee
# C

*SERVING ON Reference Committee C are (L to R): John Newton, Moultrie; William M. Headley, Milledgeville; and Donald Campbell, Marietta.*

*The following physicians served on Reference Committee C: J. Dan Bateman, Chairman, Albany; Teresa E. Clark, Vice-Chairman, Atlanta, Donald Campbell, Marietta; Joseph Morrison, Savannah; John Newton, Moultrie; William M. Headley, Milledgeville; Alexander H.S. Weaver, Macon; and Michael Cohen, Augusta.*

## Council on Legislation

**James A. Kaufmann, M.D.**

The legislative arena on both the State and the National level are and will continue to affect the quality of medical care available to all citizens.

On the National level there is the issue of DRG's being forced on the physician in office practice with the first step now mandating the DRG Reimbursement System on hospital based radiologists, anesthesiologists and pathologists. Issues such as mandatory participation in Medicare as a prerequisite to licensure are being discussed. Medicare/Medicaid reimbursement will always be an issue. Congress will continue to debate and possibly vote on mandatory alternative delivery systems be it for CHAMPUS and/or Medicare and Medicaid recipients.

At this writing six of Georgia's ten congressmen have co-sponsored Concurrent House Resolution 30 which is the AMA initiated response to the DRG issue. Neither Georgia Senator has co-sponsored Senate Concurrent Resolution 15. Another letter signed by your President John D. Watson was mailed in mid-March asking our two Senators Nunn and Fowler, Congressmen Ray, Barnard, Hatcher, and Lewis asking them to also co-sponsor the DRG Resolutions.

The Georgia legislature again had a volume of health/medical related issues introduced, debated, passed, defeated, and/or tabled during the 1987 General Assembly. There were 168 House Bills, 20 House Resolutions along with 69 Senate Bills and 14 Senate Resolutions, thus totaling 271 issues your Medical As-

sociation and specifically your Council on Legislation worked on daily during the session.

Your Council on Legislation again had as its major issue Tort Reform. The 1987 General Assembly passed several Tort Reform issues which combined gives Georgia one of the best Tort Laws in the country as it relates to the medical community. The only major issue which did not pass under Tort Reform '87 was the cap on non-economic damages. Although this cap is a major item, the issues that passed are extremely important and very beneficial when you put them together in the package of Tort Reform passed in 1987.

Many of our members made the difference and helped in the passage of Tort Reform along with the efforts of the Georgia Liability Crisis Coalition.

*All* of the MAG office staff assisted in our Tort Reform efforts. Each and everyone of them played a special role and deserve the credit for the end results.

MAG Mutual Insurance Company and its staff were instrumental with their assistance and support. MAG Mutual was the *only* insurance company in Georgia to ever step forward — give testimony along with *factual* documentation on the liability crisis and how the passage of specific issues would affect the liability crisis in Georgia. All physicians in Georgia — MAG members and others — all businessmen, small and large — all county municipalities — All Georgians should thank MAG Mutual for its tireless efforts in helping with the liability crisis.

Your Council on Legislation and the MAG staff have worked day and night since September, 1985 to pass Tort Reform. Their efforts and yours are, for the most part, now law.

Tort Reform was MAG's major effort and every State Representative and State Senator knew Tort Reform was our #1 project. Because of this, numerous other para-health groups initiated legislation hoping MAG would be too busy and too committed to Tort Reform to successfully oppose their special interest legislation.

In some respects they were correct; we were very busy and some legislators seized this opportunity to commit their vote to us on Tort Reform while at the same time sponsor, co-sponsor and tell us of their support for nurses' mandatory insurance, chiropractors' scope of practice, physical therapists as independent practitioners, optometrists' use of therapeutic drugs, etc. This made our job much more difficult.

Add to the above the numerous Georgia physicians who wrote legislators, and/or came to the Capitol and vehemently opposed the MAG Tort Reform proposals and opposed the MAG position on other issues. We have always and will always urge our members to voice their personal feelings regardless of their point of view on all legislative items but it made our job not only more difficult but ulcerogenic.

After having stated this, I am very proud to announce that, in my opinion, since there was more medical legislation in number and more medical legislation of significant importance, while we were not 100% successful, we had a very productive year. Only one bill passed both the House and Senate which we opposed. Numerous other bills which MAG opposed are still pending and will, most likely, be voted on next year.

The following is a list of the major issues that were introduced in the 1987 General Assembly.

*House Bill 1 — Senate Bill 2, Tort Reform*

A House-Senate Conference Committee took the version passed by the House and the separate version passed by the Senate and wrote what passed HB1 and SB2. These two bills contain eight very important provisions.

Summary: Conference Committee Report, SB 2

1. Statute of Limitations for Medical Malpractice

Persons who are legally incompetent because of mental retardation or mental illness and minors who are 5 years or older shall be subject to a two-year period of limitation for medical malpractice actions. For minors under the age of five, the two-year period of limitation for medical malpractice shall begin upon the child's fifth birthday.

The statute of repose for those who are legally incompetent because of mental retardation or mental illness and for minors who are 5 years from the date that the negligent or wrongful act occurred. When a minor under the age of 5 is the victim of a wrongful or negligent medical act, action may be brought anytime before the child's tenth birthday.

2. Professional Affidavit

In cases of professional malpractice, the plaintiff must file an affidavit from an expert that at least one negligent act has occurred. If the period of limitation will expire within 10 days of the filing, the plaintiff shall have 45 days to provide the affidavit. The defendant is given 30 days from the point of the affidavit's filing to respond.

3. Limited Medical Immunity

Physicians, nurses, dentists, and optometrists shall have limited immunity when their services are rendered voluntarily, without either expectation or receipt of compensation, at the request of a hospital, public school, non-profit organization or agency of the state its political subdivisions. Similar immunity is provided to hospitals, public schools, non-profit organizations and agencies of the state and its political subdivisions when they participate in providing medical services with no expectation or realization of compensation. This provision does not apply in cases involving gross negligence or willful or wanton misconduct.

Summary: Tort Reform Conference Committee Report, HB 1

4. Collateral Sources

In any civil action for damages, evidence of compensation, indemnity, insurance (excluding life insurance), wage loss replacement, income replacement and/or disability benefits, shall be admissible for consideration by the trier of fact. Reduction of an award to account for such compensation is discretionary.

5. Punitive Damages

Punitive damages are capped at $250,000 for causes of action on or after July 1, 1987. Punitive damages may be awarded when it is proven that the defendant showed willful misconduct, malice, fraud, wantonness or oppression. The purpose of such damages is to deter or punish a defendant, not to compensate a plaintiff. The cap does not apply to product liability cases, but only one award of punitive damages may be made in Georgia against a given defendant for a given product. 75 percent of each award, less litigation costs, shall be paid to the state. If the entire injury is to the feelings of the plaintiff (i.e. pain and suffering), no punitive damages shall be awarded.

6. Judicial Modification of Awards

If a jury award is clearly so inadequate or excessive as to be inconsistent with the preponderance of the evidence, the trial court may order a new trial relative to damages only, or the judge may condition the grant of a new trial upon any party's refusal to accept an amount determined by the trial court.

7. Limited Immunity for Non-profit Directors

Civil immunity is provided for members, directors or trustees service with or without compensation and to officers serving without compensation of non-profit hospitals, charitable organizations and governmental entities when they act in good faith. This provision does not apply in cases of willful or wanton misconduct.

8. Joint and Several Liability

In cases where the plaintiff is to some degree responsible for the injury or damages claimed, the trier of fact may apportion damages according to fault among the defendants whose degree of fault is greater than the injured person. Damages shall not be a joint liability and shall not be subject to any right of contribution.

*House Bill 759 — Medical Students Immunity*
(Passed)

Gives medical students immunity from suit when acting in the course of their training when they are under faculty supervision.

*House Bill 73 — Immunity — Food Donations*
(Passed)

Gives immunity to charities, etc. who donate food to the needy.

*Senate Bill 113 — Non-Profit Organizations*
(Passed)

Provides civil liability to persons serving without compensation as a member, director, trustee, etc. of any non-profit, charitable or eleemosynary institution or organization — such as County Medical Societies, Boy Scouts, Special Olympics, etc.

*House Bill 29 Torts Product Liability*
(Passed)

Provides immunity to manufacturers of products after 10 years from the date of the sale of the product.

*Mandatory Seat Belts*
(Did not pass)

Several House and Senate Bills were introduced mandating adults to wear seat belts and mandating seat belts on school buses, etc.

Some of these bills passed the Senate but did not pass the House.

*House Bill 36-House Bill 107 — AIDS*
(Did not pass)

These two bills, in the beginning, principally pertained only to specifically permitting physicians, dentists, nurses, etc. to share information relative to the medical condition of the patient. H.B. 36 would have mandated the patient tell the practitioner prior to the treatment they have AIDS.

Conference Committee Report of H.B. 107 passed the House, but due to time was not considered by the Senate. It contained the original H.B. 107 but also would have mandated that any person under age 65 who had a blood test, excluding the finger tip tests, the blood would also include the AIDS test unless that person's blood had been tested for AIDS within the previous 12 months.

*House Bill 142 — Tobacco Products — Sale to Minors Passed*

Bill makes it illegal for a minor to purchase *any* tobacco related product.

*House Bill 143 — Radiologic Technologists*
(Will be debated in 1988 General Assembly)

Would create, under the Board of Medical Examiners, a certification process to certify x-ray technologists. Would permit, for a period of 3 years, all personnel currently taking x-rays under physician supervision to be grandfathered in, not to be certified. After three years those persons must have taken approved limited certification courses or could no longer, under the physician's direction, or otherwise, take an x-ray.

*House Bill 152 — Mentally Ill Persons — Release of Information*
(This bill will be studied by the Health and Ecology Committee over the summer.)

Would require the release of patients records' upon written request of spouse, parent, adult child, and adult sibling. Said release from the

facility would have to be determined by the treating physician, the relative, etc., involved in the planning, provision or monitoring of services to the patient.

*House Bill 177 — Ambulance Service - EMT*
(H.B. 177 Passed the House but was defeated in the Senate.)

This bill stated any county with a population of 60,000 or less would be required to have only one EMT on the ambulance while all other counties would have to have at least two EMT's on an ambulance.

*House Bill 255 — Health Planning Agency*
(Passed)

Changed current law which requires hospitals to make semi-annual reports to SHPDA to only make these indigent care reports on an annual basis.

*House Bill 258/432 — Speech Pathologists/Audiologists*
(Passed)

The Medical Association of Georgia, Representatives of the Georgia Otolaryngology Society, Representatives of the Georgia Society of Speech Pathologists/Audiologists Association, Representatives of the Georgia Board of Speech Pathologists/Audiologists and a representative of the Emory and University of Georgia Speech Pathology and Audiology School met and all but the Emory and University of Georgia professor agreed on language that ultimately passed.

H.B. 258, as passed, extends the Board for six years and specifically permits physicians to delegate hearing testing to any of their employees as long as the physician is on the premises.

*House Bill 334 — Nurses Mandatory Insurance*
(Did not pass)

This proposal would mandate that all advanced nurses, those nurses licensed under the nurse practice act and designated as advanced practice nurses, would mandatorily be reimbursed by all third party carriers for their services when said policies cover reimbursement for services for which they were licensed to render.

The House Insurance Committee voted 8-1 to put H.B. 334 in a study committee for the remainder of 1986.

Please *write* all the members of this committee thanking them for their decision on this issue.

*House Bill 344 — County Boards of Health — Membership*
(Passed)

Law requires that at least one member of the governing authority be a physician. If there are fewer than 4 physicians practicing in the county or if there is no physician practicing in the county who is willing or able to serve, the governing authority may appoint a nurse, dentist, or any other person having a familiarity with and concern for the provision of medical services in the county.

*House Bill 452 — Coroners-Municipal Officers*
(Passed)

Bill permits any person holding office as mayor of a municipality of 5,000 or less is specifically authorized to serve as coroner.

*House Bill 462 — Blood Donations*
(Passed)

Permits any person who is hospitalized for a surgical procedure which has been scheduled in advance may produce a blood donor provided that the blood donation will not be detrimental to his health and that the donation is not made more than 10 days in advance of the transfusion.

*House Bill 507 — Preferred Provider*
(Passed House)

The purpose of H.B. 507 was to give the insurance commissioner clear authority over the regulation of PPO's in Georgia. The original bill permitted the group setting up the PPO to establish membership criteria, payment differential and the ability to restrict membership to the PPO as they saw fit.

H.B. 507 was changed by the House Insurance Committee — again by the House and even again by the Senate Insurance Committee. By this time very few people supported H.B. 507, therefore it was not considered by the entire Senate — but will be voted on in 1988.

*House Bill 517 — Optometrist Use of Therapeutic Drugs*
(Did not pass)

This was a proposal to permit optometrists in Georgia the right to use any therapeutic agent for any and all diseases that relate to the eye. They would be able to write prescriptions, etc.

H.B. 517 was engrossed in the House and therefore not considered by the House Health and Ecology Committee. Up until the last day of the session, Rep. DuBose Porter, Dublin, attempted to attach H.B. 517 to other germane bills. These attempts failed.

You can look forward to a very strong push by the Georgia Optometry Association to pass H.B. 517 or something similar in 1988.

*House Bill 541 — Anatomical Gifts*
(Passed)

This bill changes the Anatomical Gift law by redefining a bank or storage facility as a tissue bank or eye bank, approved by the State or an organ procurement agency or facility that is located in the State of Georgia. It states that any person 18 years of age or older of sound mind may give all or part of their body for any specified purpose.

H.B. 541 requires that on or before the occurrence of death in a hospital, a hospital representative shall notify the applicable type of bank, which shall, if appropriate, request the spouse, adult son or daughter, either parent, adult brother or sister, or guardian of the donation of all or parts of the body for donation purposes.

H.B. 541 also creates an Advisory Board on Anatomical Gifts Procurement composed of representatives of an eye bank, one representative of a tissue bank, one representative of a bone bank, one representative of an organ procurement agency, one representative of a hospital, one M.D., one representative from DHR, one representative from Medical Assistance, one representative from SHPDA.

*House Resolution 10 — Mentally Ill Study Committee*
(Passed)

Established a House-Senate Study Committee to meet over the summer to study community services for the mentally ill.

*Senate Bill 112 — Tattoo*
(Passed)

Makes it unlawful for anyone to give minors a tattoo.

*Senate Bill 133 — Workers Comp.-Occupational Diseases*
(Passed)

The bill redefines certain types of diseases and illnesses — some added to the occupational disease section — some deleted from the occupational disease section but still classified under Workers Comp. benefits. S.B. 133 deletes the requirement that byssinosis can only be treated by a Board Certified pulmonary specialist.

S.B. 133 also establishes a mechanism when medical questions are in controversy for a claim for compensation of an occupational disease the parties may agree to refer the employee to a physician specializing in the treatment of that disease.

*Senate Bill 135 — Physician Malpractice Insurance Classification*
(Did not pass)

It was a proposal to reduce the number of professional liability classification from 9 to 3. If it had passed 20% of physicians premiums would have decreased — 70% increased and 10% remain the same.

*Senate Bill 229 — Abortion-Minor*
(Passed)

This new statute specifically deals with abortion performed on minors. A minor is defined as any person under the age of 18 who is not or has not been married or who is under the care, custody and control of such persons as parent or parents, guardian or the juvenile court.

No physician shall perform an abortion on a minor unless the minor is accompanied by a parent or is furnished a signed affidavit by a parent or guardian. The minor signs a consent form stating that she consents freely and without coercion to the abortion.

If the minor elects not to comply with the above notification requirement, the minor may petition the juvenile court for permission for the abortion procedure.

*Senate Bill 235 — Chiropractors Scope of Practice*
(Did not pass)

This was an attempt by the Georgia Chiropractic Association to expand their scope of practice to permit them to treat and examine all the orifices of the body, prescribe nutritional substances, while at the same time repeal the liability language making them liable to the same degree as an M.D. for their actions.

*Senate Bill 238 — Practitioners Delegation of Authority*
(Did not pass)

The Senate Human Resources Committee did not consider S.B. 238 which would have specifically permitted M.D.'s, dentists, chiropractors, nurses, and all other health care licensed practitioners to delegate to their employees any act for which they are licensed to perform. The licensed practitioner would be explicitly liable for the actions of the employee and the practitioner would have to be on the premises when delegated functions were carried out.

*Senate Bill 260 — Death Certificate — P.A. Signs*
(Passed Senate)

S.B. 260 would permit a P.A. to sign a death certificate.

*Senate Bill 285 — Drug Samples*
(Passed Senate)

This would clearly make it illegal for anyone to sell, barter or exchange a complimentary drug sample.

*Senate Bill 286 — Medical Malpractice Claims*
(Passed)

This mandates the Board of Medical Examiners investigate a physician whenever there has been one suite settled against the physician in excess of $100,000 or any two suits settled against the physician. S.B. 286 also mandates that the physician notify the Board whenever a suit has been settled against the physician in excess of $20,000.

*Senate Bill 289 — Generic Drug Substitution*
(Passed)

Over MAG objections in the House, legislation passed changing the current two line prescription form you now use to a one line prescription form. The pharmacist may fill the prescription with a generic drug *unless* IN YOUR OWN HANDWRITING on the face of the prescription is written the words BRAND NECESSARY.

This new law goes into effect October 1, 1987.

There will be a special newsletter and MAG Journal article on this before October.

*Senate Bill 292 — Physical Therapists*
(Passed Senate)

Proposed by the Georgia Physical Therapy Association, S.B. 292 would remove that language in current law requiring that before a P.T. could initiate any treatment, etc. they must first have consultation with an appropriate licensed practitioner of the healing arts. Their proposal would permit Physical Therapists to practice independently and to receive direct third party reimbursement with *no* communications with a physician.

The Senate added liability language but the House Health and Ecology Committee did not consider S.B. 292 at the request of the Physical Therapy Association which over the summer via an agreement with MAG to review their proposal and try to find a compromise version prior to the 1988 legislative session.

*Senate Bill 315 — EMT — Paramedic — Trauma Center*
(Did not pass)

The original bill would have changed EMT's to Paramedic — dissolve the current Ambulance Service Advisory Council which designates Trauma Centers. The House removed the Trauma Center language — the Senate added language permitting legal suits against DHR and on the next to last day, the House added the contents of H.B. 177, one EMT permitted on an ambulance in counties of 60,000 or less. A conference committee was appointed. The House passed the conference committee on the final night and the Senate defeated the conference committee report the last night of the session.

*Senate Bill 367 — Informed Consent*
(Did not pass)

S.B, 367 passed the Senate Special Judiciary Committee but was not considered by the entire Senate. S.B. 367 would have mandated written informed consent on *all* surgical procedures. This consent would have to list risks, alternatives and side effects of all surgical procedures.

*Senate Bill 374 — Arbitration — Medical Malpractice Cases*

Introduced late in the session for the purpose of being studied over the summer. S.B. 374 is an attempt to *mandate* binding arbitration on all medical malpractice cases.

*Senate Resolution 20 — Seat Belts-Buses*
(Passed)

Creates a Senate Study Committee to study the feasibility and costs of mandating all school buses be equipped with seat belts.

*Senate Resolution 119 — Organ Donor & Transplant*
(Passed)

Creates a Senate Study Committee to study the needs and availability of organ donation in Georgia.

*Senate Resolution 165 Head Injury Treatment*
(Passed)

Creates a Senate Study Committee for the head injured in Georgia — the availability of treatment in Georgia for the head injured and the rehabilitation required for the head injured.

*Senate Resolution 175 — Nursing Home Industry*
(Passed)

Create a Senate Study Committee to study *all* aspects of the Nursing Home Industry in Georgia.

Those are just a few of the bills that were of interest to the MAG and the physicians throughout Georgia. Many of the bills were introduced which could have adversely affected the liability insurance climate in Georgia — the court climate and the jury climate. Many other bills were germane to a number of the bills which MAG opposed. Your Legislative Committee and specifically those MAG employees who were at the capitol on a daily basis had to monitor all 277 bills every day to make sure nothing adverse was taking place.

The legislative session of 1987, more so than any previous year, was busier and much more confusing than any other session. On numerous days there were 3, 4 and even 5 different House and Senate Committee meetings held at the same time where legislation was being discussed and voted on of significant interest to MAG. Your staff along with the Physician Involvement Program and physician volunteers did a masterly job in passing meaningful legislation while at the same time making sure adverse legislation did not pass. Only one bill passed which MAG opposed. Our average for 1987 was *EXCELLENT!*

The Physician Involvement Program proved this year to be very, very helpful and needs to be continued with every MAG member being urged to participate over and over again. This year showed a need for the PIP to be expanded in number of week days as well as number of physicians and staff guidance for those physician attendees.

With the help of the MAG Auxiliary a new program was initiated midway through the 1987 session. A phone bank program was established in order to get current data to local MAG members via telephone calls from the MAG office by Auxiliary members. As any new program goes, it had its bugs, but worked extremely well and was appreciated by those physicians called.

Rusty Kidd, our very capable Director of Legislative Activities, did an almost unbelievable and masterful job this session in spearheading our legislative efforts and our new legislative team. His tasks in 1988 will be more difficult.

MAG had two new staff people who assisted Rusty Kidd, our Director of Legislative Activities, in various ways, Richard Greene, MAG's General Counsel, and Ray Williams, MAG employee, assigned to the Georgia Society of Ophthalmology. Both Richard and Ray were invaluable to the success of MAG's legislative program for 1987.

**Recommendations**

1) That all MAG members write a thank you letter to Lt. Governor Zell Miller for his leadership in pushing Tort Reform.

   The Honorable Zell Miller
   Office of the Lt. Governor
   State Capitol Building
   Atlanta, GA 30334

2) That the PIP be continued in 1988 and that it be expanded to Monday-Thursday.

*WILLIAM W. MOORE, JR., a neurosurgeon from Atlanta and Past President of the MAG.*

3) That the MAG staff assigned to the PIP program make sure all PIP attendees are adequately briefed on issues of importance — the daily activity and are escorted daily to their State Representative and Senator.
4) That Mrs. Barbara Tippins, President, MAG Auxiliary, and Mrs. Jan Collins, Legislative Chairperson, MAG Auxiliary, be commended for their support on the phone bank program and their support of all MAG legislative programs.
5) That MAG and the MAG Auxiliary continue the phone bank system in 1988.
6) That all members of the auxiliary who volunteered to assist in the phone bank program be written a thank you letter.
7) That MAG continue the Doctor-of-the-Day program.
8) That MAG commend Ms. Pam Hartman, nurse for the Doctor-of-the-Day program.

**House Action**

*Recommendations 1, 2, 3, 4, 5, 6, 7, and 8:* Adopted

*Recommendation 9:* Adopted as amended to read:

*"That Dr. James A. Kaufmann be commended for his continued legislative expertise and his tireless dedication in behalf of the membership of MAG."*

## Public Relations Committee

**Jeffrey T. Nugent, M.D., Chairman**

*Referred to:* Recommendation 1 — Reference Committee C, Recommendation 2 — Reference Committee A/F.

*Editorial Note: The report of the Public Relations Committee appears in its entirety in the Report of Reference Committee A.*

**Recommendations**

1. The Public Relations Committee recommends that the remainder of the unspent funds from the 1986 assessment of membership for a Public Education Campaign for Tort Reform be maintained in a separate account for a for a continued effort in 1987 and 1988 to further obtain key Tort Reform Legislation, which was not passed by the Georgia Legislature in 1987. Particularly important to us is a limitation on pain and suffering awards, structured settlements, attorney contingency fee regulation, and any other elements of Senate Bills 1 and 2, which were not passed by the Legislature.

2. We request a $50,000 budget for 1987-88 for two purposes: primarily to continue with the program co-sponsored with the MAG Auxiliary entitled "You Can Say No," Teenage Pregnancy Prevention Campaign, and secondly to develop a Public Education Campaign concerning the responsibility of the citizens of Georgia to take charge of their own preventive health lifestyle practices, develop price consciousness in the purchase of health services, and promote understanding of the elements of quality health care.

**House Action**

*Recommendation 1:* Adopted as amended which reads:

*"That all remaining funds and accrued interest resulting from the 1986 Tort Reform Assessment as of May 31, 1987, should be placed in reserve in such a manner designed to increase the value of such funds.*

*"Expenditures shall be made in subsequent years to promote additional tort reform issues and to protect and defend tort reform issues which are now law. All expenditures shall be approved by the MAG Executive Committee.*

*"The Executive Committee shall report to the Board of Directors at its September and April meeting a detailed accounting of these funds."*

See Reports of Reference Committees A and F for House Action on Recommendation 2.

## Third Party Payors Committee

**C. Peter Lampros, M.D., Chairman**

*Referred to:* Recommendation 1 — Reference Committee C, Recommendation 2 — Reference Committee B.

*Editorial Note: The Third Party Payors Committee's report is printed in the Report of Reference Committee B.*

**Recommendations**

1. That the MAG conduct a careful study of the topic of physician drug dispensing and offer policy guidelines on the ethical, management, and legal considerations involved.

2. That the MAG use its resources to keep physicians informed on the reimbursement changes occurring in Medicare and Medicaid and express strong opposition to those payment system changes which interfere with the efficient and high quality practice of medicine.

**House Action**

*Recommendation 1:* Adopted as amended which reads: *"That the MAG conduct a study of physician drug dispensing and submit policy guidelines on the ethical, management, and legal considerations involved in the MAG Board of Directors."*

See Report of Reference Committee B for House Action on Recommendation 2.

## Ad Hoc Committee on Medical Care for the Disadvantaged

**John Rhodes Haverty, M.D., Chairman**

The Ad Hoc Committee on Medical Care for the Disadvantaged was appointed in August, 1986 by MAG President, John D. Watson, Jr., M.D., to study the important issue of medical care for the indigent. Assuring access to health care for the medically indigent — individuals with little or no private or public health insurance and without the economic means to pay for essential medical services — has become one of the most pressing medical care issues of the 1980's and one requiring the careful attention of organized medicine.

As Chairman of the committee, I felt it important to enlist the views of other community leaders throughout Georgia to arrive at some possible solutions. A committee was formed with a strong core of Association physicians, and, in addition, representatives from the Georgia State Medical Association, the Greater Atlanta Coalition on Health Care, Morehouse Medical School, Mercer University School of Medicine, Georgia Board of Human Resources, the Public Health Department, the Black Women's Health Project of Atlanta University, and the Georgia Refugee Health Program. The committee also comprised representatives from, or heard speakers from, the following organizations: the Kentucky Medical Association, American College of Gynecology and Obstetrics, the National Medical Association, American Medical Association, Georgia House of Representatives and Senate, the Georgia Legislative Black Caucus, and the Department of Medical Assistance.

The committee met on six occasions since August, 1986 to identify and document programs which might contribute to some possible solutions. We spent considerable time in attempting to define the issues and determining those that would need to be addressed to understand the indigent problem.

An analysis of these issues is complicated by the problem of identifying individuals who are medically indigent. For the most part, the committee narrowed its interests to that population which is uninsured or underinsured and presently uncovered by publicly funded programs. It was decided that focus would be given to three principal areas:

1) Professional Association and Business Initiatives;
2) Legislative or other public sector proposals; and
3) Individual practitioner activities and strategies.

In our study of Professional Association and Business Initiatives, a national survey was conducted of present indigent health care activities occurring within the 50 state medical societies. A total of 35 state Associations responded, of which some 15 indicated indigent medical care as a high priority for their Association activities.[1] At least 11 Associations had appointed a special committee to study the issue and 18 were developing legislative proposals on the topic. This was particularly true of the 10 southeastern states responding. A similar study conducted within Georgia county medical societies revealed that a few organized efforts existed to provide free health care to the poor, although prominent views were that considerable care was being provided.[2]

The committee heard reports of the Medical Association of Atlanta's Health Care Clinic for the Homeless, and from Dr. Harrison Rogers of AMA's policy emphases. Dr. Russell Travis of the Kentucky Physicians Care Program — one of the only formalized statewide free care physician referral programs in the nation — presented a detailed report of the design and outcome results of the Kentucky Medical Association's project.[3]

### Legislative

Although the provision of funding of health care services for the medically indigent has long been a concern of national, state and local policymakers, recent events have brought it to the forefront. In their 1984 legislative sessions, 22 states introduced legislation with the objective of improving the medically indigents' access to health care. Since 1984, 20 states have organized legislative or gubernatorial study commissions with financing health care for the medically indigent as the primary focus or an important secondary concern of medical care cost-containment efforts.[4]

In November, 1984 the Georgia Joint Hospital Care for the Indigent Study Committee published a significant report on the scope of the problem in Georgia and some possible solutions.[5] The MAG Ad Hoc Committee heard from the Chairman of the Study Committee and considered these findings in their analysis. Other resource documents considered include the "National Conference of State Legislatures Alternative Funding Options for Care of the Medically Indigent"[6] and "Access to Care for the Medically Indigent," published by the Academy for State and Local Government.[7]

*Towards a Final Report:*

Following a final meeting after the MAG Annual Session, the Ad Hoc Committee on Medical Care for the Disadvantaged plans to issue a complete report of its findings and recommendations. It is hoped that this report will provoke action towards a well-planned solution of this critical medical problem.

In the interim, the committee respectfully submits the following recommendations to the MAG House of Delegates for its consideration:

**Recommendations**

1) That the MAG support a state policy of medical indigent care funding which involves the coordination of public and private sector options.
2) That the MAG encourage the appointment of a gubernatorial study committee to continue the efforts of the 1984 Joint Hospital Care for the Indigent Study Committee. This committee would develop more specific proposals for addressing the problems of medical indigency, particularly the funding of such efforts.
3) That the State of Georgia continue its expansion of the State Medicaid program to include indigent populations not presently covered.
4) That MAG endorse the AMA policy encouraging all physicians to continue to accept assignment for Medicare beneficiaries whose economic situations dictate the need for this type of assistance.
5) That Georgia physicians continue to accept Medicaid patients whether through the state reimbursement process or through donated services.
6) That Georgia physicians continue to care for other medically indigent patients whether or not they are covered by government programs, insurance, or other third party payment plans.
7) That MAG encourage the expansion of participation by physicians in public health clinics; food kitchens for the poor; services to street people, to needy refugees, farmers, and other groups who "fall between the cracks" of government-funded medical assistance programs.
8) That the MAG encourage employers to provide health insurance coverage for all their employees and urge insurance companies to facilitate this outcome.
9) That MAG continue to collect and analyze data relating to health care for Georgia indigents, and develop an informational program for physicians, their patients, and the general public on the services, resources, and facilities available for the medically indigent.
10) Finally, we recommend that an implementation committee be appointed by the President of MAG to oversee the activities emanating from the Committee on Medical Care for the Disadvantaged.

**References**
**Ad Hoc Committee on Medical Care for the Disadvantaged**


1. "Medical Association of Georgia Indigent Health Care Survey of State Medical Associations," October, 1986.
2. "Medical Association of Georgia Indigent Health Care Survey of County Medical Societies," December, 1986.
3. "Opening the Door for Medically Indigent," *American Medical News*, pg. 3, 11 September, 1986.
4. "State Indigent Care Initiatives," *Washington Report on Medicine and Health*, November 4, 1985.
5. Georgia State Legislature, "Report of the Joint Hospital Care for the Indigent Study Committee," November, 1984.
6. "Alternative Funding Sources for Care of the Medically Indigent," National Conference of State Legislatures, Denver, Colorado, July, 1986.
7. "Access to Care for the Medically Indigent: A Resource Document for State and Local Officials," Academy for State and Local Government, Washington, D.C., March 30, 1985.


**House Action**

*Recommendation 1:* Adopted as amended with reads:

*"That the MAG support the development of a state policy of medical indigent care funding."*

*Recommendation 2:* Adopted as amended which reads:

*"That the MAG encourage the appointment of a gubernatorial study committee to continue the efforts of the 1984 Joint Hospital Care for the Indigent Study Committee."*

*Recommendation 3:* Adopted as amended which reads:

*"That the state of Georgia maximize its expansion of the State Medicaid program to include indigent populations not presently covered."*

*Recommendations 4, 5, 6:* Adopted by substitution which reads:

*"That the MAG reaffirm its policy that no patient in Georgia be denied medical care for lack of funds."*

*Recommendation 7:* Adopted.

*Recommendation 8:* Adopted by amendment which reads:

*"That the MAG encourage its members and other employers to provide health insurance coverage for all their employees and urge insurance companies to facilitate this outcome."*

*Recommendation 9:* Adopted as amended which reads:

*"That MAG continue to collect and analyze data relating to health care for Georgia indigents."*

*Recommendation 10:* Adopted by substitution which reads:

*"That the MAG appoint an indigent care committee to carry out the directives of the 1987 House of Delegates and to carry out the directives of the Board of Directors of future recommendations submitted by The Ad Hoc Committee on Medical Care for the Disadvantaged.*

## Resolution 1

## Physician DRG's/RAPS

**E. W. Holloway, Jr., M.D.**

RESOLVED, that the Medical Association of Georgia should voice its opposition to the federal administration's plan for physician DRG's, and be it further

RESOLVED, that the Medical Association of Georgia should convey its position to the members of our state's Congressional delegation, urging their opposition to this proposal.

**House Action**

Adopted first Resolved.

Adopted second Resolved as amended which reads:

*"RESOLVED, that the Medical Association of Georgia should convey its position to the members of our state's Congressional Delegation who have not committed their opposition to this proposal."*

## Resolution 2

### Increase of Cigarette Excise Tax

**Medical Association of Atlanta**

RESOLVED, that the MAG officially endorse an increase of the federal excise tax on cigarettes with the provision that income from this additional taxation be earmarked as revenues for Medicare; and be it further

RESOLVED, that MAG's position on these issues be officially communicated to the members of Georgia's delegation to the United States Congress, soliciting their support.

**House Action**

Adopted first and second Resolveds.

Adopted a Third Resolved by addition which reads:

*"RESOLVED, that the Medical Association of Georgia ask the AMA to seek passage of this tobacco tax by the U.S. Congress."*

## Resolution 9

### Tort Reform

**Gwinnett-Forsyth Medical Society**

RESOLVED, that the MAG continue its efforts toward passage of part or all of the above measures in the 1988 Georgia General Assembly.

**House Action**

Adopted by amendment which reads:

*"RESOLVED, that the MAG continue its efforts toward passage of meaningful Tort Reform measures in the earliest time frame possible."*

## Resolution 10

### Alternatives to Tort Reform

**Ralph A. Tillman, M.D.**

RESOLVED, that the 1987 House of Delegates recommends that the Executive Committee charge a committee (either standing or ad hoc) with the task of seeking alternative means to properly and expeditiously compensate the deserving medically injured patient and/or family; and be it further

RESOLVED, that this committee report its findings and/or recommendations to the Executive Committee by November, 1987.

**House Action**

Adopted.

## Resolution 15

### Generic Drugs

**DeKalb Medical Society, Inc.**

RESOLVED, that an ad hoc committee be appointed to do an in depth study of the generic drug controversy and make recommendations to the Executive Committee/Board of Directors in order to develop a position or policy regarding generic drugs and attempt to promote favorable legislation.

**House Action**

Adopted as amended which reads:

*"RESOLVED, that an Ad Hoc Committee be appointed by the President of MAG to do an in depth study of the generic drug controversy and make recommendations to the Executive Committee/Board of Directors in order to develop a position or policy regarding generic drugs and attempt to promote favorable legislation."*

## Resolution 22

### Funding of Catastrophic Medical Care

**Louis H. Felder, M.D.**

RESOLVED, that MAG support the concept of governmental support for catastrophic health care expenses for Medicare beneficiaries; and be it further

RESOLVED, that MAG develop position statements regrading the prevention of economic abuse and jeopardy of the Medicare program, as well as regarding the quality of medical care; and be it further

RESOLVED, that MAG forward to its Congressional representatives details of its position regarding these issues before said issues are made into law.

**House Action**

Adopted by amendment and referred to MAG Board of Directors and which reads:

*"RESOLVED, that MAG support the concept of Catastrophic Health Care for Medicare beneficiaries, preferably by the private sector, and be it further*

*"RESOLVED, that the MAG forward to its Congressional Delegation details of its position regarding these issues before a government program is made into law."*

## Resolution 24

### Generic Drug Substitution

**Richard A. Wherry, M.D.**

RESOLVED, that the Medical Association of Georgia make one of its top priorities in the next session of the Georgia General Assembly, the reinstatement of the previous sociation of Georgia, through its various media and public education avenues, provide information to the public on the generic drug issue.

**House Action**

Filed.

*ALEXANDER H. S. WEAVER, from Bibb County, served on Reference Committee C.*

## Resolution 34

### Definition of Expert Witness

**Medical Association of Atlanta**

RESOLVED, that the Medical Association of Georgia define "expert witness" for the purpose of testifying in malpractice cases; and be it further

RESOLVED, that such definition be as follows: An expert witness is a board certified physician engaged in clinical practice in the specialty for which he is testifying at least 75 per cent of the time.

**House Action**

Adopted as amended and referred to MAG Board of Directors:

*"RESOLVED, that the MAG define 'expert witness' for the purpose of testifying in a Medical Malpractice case; and be it further*

*"RESOLVED, that such definition be as follows:*

*"An expert is a physician who has completed an AMA approved residency training program in the specialty in which he or she are testifying and is engaged in the clinical practice of that specialty at least 75% of the time."*

## Resolution 36

### For Passage of a Mandatory Seat Belt Law in Georgia

**William Weston, III, M.D., Delegate**

RESOLVED, that the Medical Association of Georgia endorse passage and enforcement of a front seat mandatory seat belt law for all persons in Georgia during the 1988 Legislative session.

**House Action**

Adopted.

## Resolution 37

### Expert Witnesses

**DeKalb Medical Society, Inc.**

RESOLVED, that MAG vigorously oppose the use of physicians as expert witnesses in medical malpractice cases who are either retired or do not practice on a day to day basis in a field of medicine related to the case being considered by the court; and be it further

RESOLVED, that this position be incorporated into the legislative package to be presented to the 1987 General Assembly.

**House Action**

Filed.

## Resolution 41

### Legislation

**F. William Dowda, M.D.**

RESOLVED, that this House of Delegates go on record as being inalterably opposed to this legislation and that no compromise which would restrict a physician's freedom to delegate any action in his office to his personnel whom he feels are capable is acceptable.

**House Action**

Adopted as amended to read:

*"RESOLVED, that the MAG reaffirm its position of support of legislation which would permit a physician freedom to delegate any action in their office to their personnel whom they feel are capable."*

## Resolution 42

### Legislation

**F. William Dowda, M.D.**

RESOLVED, that this House instruct the AMA to give top priority to the following:

1) Repeal of the Excise penalty tax on excess retirement distribution
2) Repeal of the Excise tax on excess retirement accumulation
3) Repeal of the requirement of conformity of tax years of personal service corporations
4) Repeal of the requirement of 10 years of plan participation (act code section 1106 (F))
5) Repeal of the requirement of plan participation by the lesse of 40% of all employees (act code section 1112 (A))
6) Reinsertion of IRA deductibility into the tax code

**House Action**

Referred to MAG Board of Directors.

## Resolution 43

### Legislation

**F. William Dowda, M.D.**

RESOLVED, that the MAG hire a consultant to determine the efficacy of our local effort, to determine if a restructuring of our effort would be beneficial and to determine if a change in the direction of GaMPAC and AMPAC would be beneficial.

**House Action**

Not adopted.

# REPORT
# Reference Committee
# D

*WILLIAM R. HARDCASTLE from DeKalb County served as chairman of Reference Committee D.*

*During its meeting of April 24, Reference Committee D gave careful consideration to its referred reports and resolutions. The following physicians were members of that Committee: Garland D. Perdue, Jr., Leon H. Bush, Rodney M. Browne, Roland S. Summers, Larry Brightwell and Dan B. Stephens.*

## Hospital Medical Staff Section

**William B. Jones, M.D., Chairman**

As a result of action taken by the 1986 MAG House of Delegates meeting, the Hospital Medical Staff Section conducted a survey in February, 1987 on the impact of the many changes occurring within the hospital-medical environment and the role and effectiveness of the section.

A random sample of some 1500 physicians was taken, 750 of whom were hospital-based and 750 non-hospital-based in addition to including all hospital chiefs of staff and medical directors. The study design also involved considerations for age and geographic region.

Issues researched ranged from such topics as joint ventures; the medical staff's voice in running the hospital, in governing board decisions; hospital cost-containment; the Professional Review Organization; and DRGs.

Responses to date reveal a better than 30% response rate to the survey and the general opinion that the section should proceed in its attempts to involve medical staff interests in the federation of local and state medical societies. A complete report of the Hospital Medical Staff survey findings will be available at the April, 1987, House of Delegates meeting.

The HMSS also hosted a luncheon in January, 1987, for all governing council members, AMA delegates and alternates, and representatives as a part of the MAG Leadership Conference activities. Dr. Thomas R. Reardon, AMA-HMSS governing council member, and past president of the Oregon Medical Society, presented an overview of HMSS activities nationwide and new challenges for the future.

In 1987-88, the section anticipates hosting a series of state and/or regional seminars addressing the topic interests identified in the HMSS survey findings. The MAG-HMSS will also join efforts with the AMA-HMSS in their grass roots campaign to stimulate participation in state and local HMSS organizations and, consequently, to increase the strength and accumulative impact of all medical staffs. Collectively, there are more than 2200 physicians nationwide who have attended AMA-HMSS meetings. During the past four years the AMA has acted favorably on more than 90% of the HMSS-sponsored resolutions. By exchanging information, establishing medical staff policies, and formulating a unified voice, the AMA-HMSS has become an influential forum of which Georgia should be adequately represented.

**Recommendation**

1. That based on the recent survey findings of the MAG-HMSS, an energetic grass roots campaign be undertaken to stimulate participation in the state HMSS and at least one to two workshops be held on topics of high and/or emerging interests to the membership.

**House Action**

Adopted as amended by addition of the following sentence: *And in the event that the proposed campaign and workshops fail to stimulate substantial physician participation in the state HMSS, that the Section be formally abolished at the 1988 MAG House of Delegates.*

## Committee on Professional Liability Support Groups

**Earnest C. Atkins, M.D., Chairman**

As a result of a resolution introduced into last year's House of Delegates, the MAG Executive Committee appointed this Committee to "formulate guidelines and appropriate instruction wherein local support groups can be organized throughout the state; to assist and counsel MAG members and families undergoing professional liability lawsuit. I am pleased to say that our Committee has organized, held five meetings during the past year, and has done a lot of work.

We have sponsored a series of six articles on "You and Malpractice Stress" in the *Journal of the Medical Association of Georgia:*

1) "What Happens to You When You're Sued?" (October '86)
2) "One Physician's Story" (November '86)
3) "Two Spouses' Views" (December '86)
4) "The Office Staff's Perspective" (January '87)
5) "A Death in the Family" (February '87)
6) "Malpractice Suits: Their Effect on Doctors, Patients and Families" (March '87)

We have published a brochure "How to Form Liability Support Groups" and mailed it to every county medical society president, every MAG member, and every Auxiliary member.

We have brought Dr. Sara Charles, leading authority on "malpractice stress syndrome," from Chicago to speak at MAG's recent Leadership Conference.

We have helped county societies begin to form support groups in DeKalb County, Bibb County, Dalton, Savannah; and have talked with other physicians across the state who want to serve as "supporters" and "listeners."

We are also preparing a brochure "Tips on How to Support" for mailing to all MAG and A-MAG members.

All this work could not have been done without the steadfast commitment of our Committee members. They are: Hoyt C. Dees, Atlanta; David M. Nichols, Decatur; Mrs. William C. Tippins, Jr., Dunwoody; Mrs. Roy W. Vandiver, Stone Mountain and Mrs. Charles B. Thomas.

The Chairman especially wishes to thank the members of the Auxiliary for their support and hard work. On behalf of the Committee, the Chairman wishes to thank the staff members Dr. Steve Davis and Talitha Russell for their ideas and participation in the success of our project.

And for the Committee I would like to express our thanks to the MAG Board of Directors, which last September authorized a generous appropriation of funds to allow the printing and mailing of our brochures.

Our work continues, as we seek to educate Georgia physicians on malpractice stress. We have therefore added the recommendation below.

**Recommendation**

That MAG encourage every county medical society, in conjunction with its Auxiliary chapter, to conduct in the coming year an education program on the psychological and physical impact of liability lawsuits on physicians, and on the benefits of peer "support groups" in alleviating these symptoms of malpractice stress.

**House Action**

Adopted.

Added and adopted a second recommendation:

*"That MAG encourage all medical liability insurance carriers in Georgia to send information on professional liability support groups in Georgia to every physician who notifies the company of an impending malpractice lawsuit."*

## Scientific Assembly Committee

**Roland S. Summers, M.D., Chairman**

Last fall, November 8-11, the Southern Medical Association held its 80th Annual Scientific Assembly in Atlanta. As in 1978 and 1982, when SMA came to Atlanta, the MAG officially cosponsored the meeting. Accordingly we did not hold our own MAG Scientific Assembly, which traditionally we hold the weekend before Thanksgiving.

Scientific sessions of the meeting were planned largely by the Section Secretaries of the SMA's 21 specialty sections. In several instances, state or metropolitan specialty societies in Georgia organized excellent speaker sessions as part of the program. In this regard I would like to commend the following for their collaboration with SMA:

Allergy and Immunology Society of Georgia
Margaret Guill, M.D.

Georgia Neurosurgical Society
Fremont Wirth, M.D.

Atlanta Society of Pathologists
Hiliary Hargreaves, M.D.

Georgia Chapter, American College of Surgeons
LaMar S. McGinnis, M.D.
Ellis B. Keener, M.D.

Social activities, held mostly at the Marriott Marquis Hotel, were capped on Saturday night by a splendid reception at the High Museum and exclusive performance by the Atlanta Symphony Orchestra. Dr. Bill Collins of Atlanta, Chairman of SMA's Local Arrangements, deserves commendation for his very good work.

As a result of all this effort, Southern Medical claims that attendance at its Atlanta meeting was the highest it has been in 10 years, with a total physician attendance of 3,141; of these 1,407 were Georgia physicians.

This fall we return to our usual format of holding MAG's Scientific Assembly in cooperation with state and metro specialty societies. Thus far we have lined up CME programs in the following specialties:

allergy
chest disease
emergency medicine
neurology
neurosurgery
ophthalmology
otoparyngology/head & neck surgery
pathology
plastic surgery
psychiatry
surgery

Our meeting place will once again be the Ritz Carlton Buckhead Hotel, site of our very successful 1984-'85 meetings.

We have also begun to select a site for our 1988 Scientific Assembly, and have obtained the offer of a very desirable $93 single/double room rate from the Ritz. We were not able to get our usual pre-Thanksgiving weekend however; the Ritz has offered instead the weekend of November 11-13 for our 1988 Scientific Assembly. We realize this will conflict with the Georgia-Auburn game at Auburn. We have evaluated other hotel facilities, but among those available to us, we have judged the Ritz to be superior and therefore worth risking a slight drop in overall attendance.

Our main concern, though, is the Ritz's limited space. Because we wish to offer a commercial exhibit area during our meeting, the Committee and staff will continue to evaluate the Ritz-Carlton Buckhead Hotel, and other facilities, so that we may continue to offer a good scientific meeting at the most desirable, feasible site.

I should add that we have been contacted by several Georgia specialty groups about MAG's role in the SMA meeting last fall. In some cases, very strong criticism has been voiced over the inadequate promotion of the specialty meetings among Georgia physicians, especially those who are not members of Southern Medical. We have in fact been encouraged, when SMA returns to Atlanta in 1990, not to cosponsor its 84th Annual Scientific Assembly.

Because of those concerns, we propose the appended resolution.

As Chairman I would like to express appreciation to the members of my Committee, very helpful and collegial fellows all: Edwin C. Evans, Atlanta; Ellis B. Keener, Gainesville; Arthur J. Merrill, Jr., Atlanta; George W. Shannon, Columbus; Carter Smith, Jr., Atlanta and William C. Waters, III, Atlanta.

**Recommendation**

The MAG evaluate its function and responsibilities in the quadrennial SMA-MAG Scientific Assembly, and that the Committee on Scientific Assembly report to the Board of Directors on this subject.

**House Action**

Adopted.

## Medical Schools Committee

**William C. Waters, III, M.D., Chairman**

Our Committee was established to serve as liaison for MAG with the state's medical schools and to assure communication between academic physicians and private practitioners.

We helped promote this necessary dialogue in October 1985 by holding MAG's 11th Biennial Conference on Medical Education. This fall we intend to hold our 12th such Conference.

Our plans are to discuss a variety of issues of mutual concern to town and gown. One of them will be related to medical manpower. We have read recently that Dr. Robert Petersdorf, new president of the Association of American Medical Colleges (AAMC) has stated that a national study of physician manpower is one of his top priorities. In Georgia, there is also already underway a medical manpower study being

conducted by the Joint Board of Family Practice, the Composite State Board of Medical Examiners, and DHR. Its report is due out this summer — in time to provide ample material for our discussions.

But the primary topic of our upcoming Biennial Conference will be the medical school's increasing role in the practice of medicine. Medical school deans across the country are facing a crisis in uncompensated care. This in turn is exacerbating the town-gown syndrome, as schools are having to compete with the private practicing physician. What's the situation in Georgia? Should something be done about it? If so, what? and by whom?

To plan our agenda on these and other topics, we hope to work with the several deans, and then (as in '85) to invite a select group of academic and practicing physicians, medical school administrators and other interested individuals. We expect to have a strong, fruitful Conference, and want to make sure we have the support of the House of Delegates (see following recommendation).

As always, I wish to express sincere thanks to my colleagues serving as members of this Medical Schools Committee: S. William Clark, III, Waycross; Lois T. Ellison, Augusta; Frank L. Ferrier, Atlanta; Harold L. McPheeters, Atlanta; James S. Maughon, Atlanta; George W. Shannon, Columbus; H. Kenneth Walker, Atlanta; Regina Benjamin, Macon; and James McGhee, Atlanta.

**Recommendation**

That the Medical Association of Georgia, in coordination with the four medical schools of the state, hold a Conference on Medical Education this fall, to discuss issues of mutual concern to both academic and private practicing elements of the state's medical community.

**House Action**

Adopted.

## Cancer Committee

**LaMar S. McGinnis, Jr., M.D., Chairman**

Three concerns continue to occupy the Cancer Committee of MAG. (1) The status of the Central Cancer Registry. (2) The status of informed consent laws regarding the cancer patient. (3) The status of state government involvement in the cause of cancer care in Georgia.

During 1986 MAG became totally disassociated from the Georgia Central Registry. In the summer of 1986 the operation of the Central Registry was taken over by the SEER program, and in July all computer tape information regarding approximately 200,000 patients in the Central Registry was transferred to compatible tapes in the SEER program. The Central Registry is now operated by SEER under contract with DHR with continued inadequate funding in the amount of $114,000 per year. Doctor Ray Greenberg, as director, produced an excellent summary of reported cancer data from our state; and this is now available on request. However, only about 3,000 cases per year are being reported from ten participating hospitals, out of an estimated 20,000 new cancer cases per year in Georgia. Greater participation is needed, and computerization of hospital registries on a compatible basis with a central registry will facilitate this participation. Ultimately, a population-based registry reporting statewide, reliable, site incidence with age, sex, and race, stage of diagnosis, survival and demographic analyses, with annual reporting, would be a desirable goal. Refinement and enlargement of this data base could be most helpful to all concerned with cancer care in Georgia.

The booklet, "About Breast Cancer," is available for purchase from the Composite Board of Medical Examiners. State law recommends that this booklet be furnished to all patients *suspected* of having breast cancer. We recommend that physicians do this and have made this recommendation through announcements in MAG's *Newsletter.* No further activity regarding informed consent for the cancer patient was reported during the current legislative session.

The Cancer Committee remains concerned regarding inadequate funding of various cancer activities by state government. The Central Registry is unable to become a statewide population-based registry with funding of only $114,000 per year. The State Aid Cancer Program remains woefully underfunded; and as a result, the number of hospitals participating continues to contract; despite the fact that physician services are offered at no charge.

The well-conceived "Community-Based Cancer Control Program," developed by the Governor's Cancer Advisory Committee a few years ago, continues to languish in the realm of low priority by state government. Despite efforts by MAG, the Georgia Division of the American Cancer Society, the Governor's Cancer Advisory Committee, and others, the program has not advanced in priority to a point where it will be considered for funding. The Cancer Committee has discussed this problem repeatedly and presently is considering the development of a state cancer plan modeled after some of the successes obtained in states such as Texas, Florida, California, and Pennsylvania. The development of these plans has come from initiation within the legislature, were extremely comprehensive in nature, and included such items as the mandatory reporting of cancer, a requirement for a central registry with adequate funding, and a requirement that hospitals furnish cancer data to the Central Registry. Further goals that were considered were to lower the risk for developing cancer; to detect, diagnose, and treat cancer earlier when cure is more likely; to improve the accessibility, availability and quality of cancer resources, services, and programs; to

*MEMBERS OF REFERENCE COMMITTEE D included L to R: Leon H. Bush, Roland S. Summers, and Rodney M. Browne.*

advance control of cancer through development and application of new prevention, detection, diagnostic and therapeutic methods and techniques in the community. The Cancer Committee is beginning the development of such a plan and will seek legislative advocates as sponsors.

**Recommendations**

1) That the MAG support the new Central Registry and encourage hospitals to participate in reporting information to the Central Registry.
2) That the MAG continue to encourage hospitals to develop hospital Cancer Programs and gain approval of these programs by survey from the Commission on Cancer of the American College of Surgeons.
3) That MAG support the activities of the Cancer Committee as it develops a comprehensive, statewide Cancer Program in concert with the Georgia Division of the American Cancer Society and the Governor's Cancer Advisory Committee and with key members of the Georgia Legislature.

**House Action**

Adopted all three recommendations.

## Continuing Medical Education Committee

**George A. Shannon, M.D., Chairman**

Through its work this past year, our Committee continues to maintain its record of efficient service in promoting continuing medical education across the state. Our activities have been channeled in several areas.

*Accreditation*

Our main achievement this year has been the publication of an *MAG Manual on CME Accreditation,* our 33-page guidebook to national requirements for accredited CME, the Committee's procedures for accrediting CME providers, and our policies on joint sponsorship of CME meetings. We have distributed these throughout the state, and will use them in the future as the basis of our accreditation activities.

Our ongoing job as a committee remains advising and accrediting Georgia organizations and institutions which provide continuing medical education. In the past year we've resurveyed eight hospitals and state specialty societies, and extended their period of accreditation according to their ability to meet the ACCME *Essentials* for Category 1 continuing medical education. We've also conducted an initial survey visit of Kennestone Hospital and South Georgia Medical Center, and granted 2 years' provisional accreditation to each institution.

As of this writing, sixteen specialty societies and twenty-one hospitals in the state are accredited for CME by the MAG. These 37 providers are:

John D. Archbold Memorial Hospital, Thomasville
Athens General Hospital
Atlanta Society of Pathologists
Augusta Obstetrical & Gynecological Society
DeKalb General Hospital
Georgia Academy of Family Physicians
Georgia Academy of Family Physicians Educational Foundation
Georgia Affiliate, American Heart Association
Georgia Baptist Medical Center, Atlanta
American Academy of Pediatrics, Georgia Chapter
American Cancer Society, Georgia Division
Georgia Gastroenterologic Society
Georgia Orthopaedic Society
Georgia Psychiatric Association
Georgia Radiological Society
Georgia Rheumatism Society
Georgia Society of Anesthesiologists
Georgia Society of Ophthalmology
Georgia Surgical Society
Glynn-Brunswick Memorial Hospital
Greater Atlanta Otolaryngology/Head and Neck Surgery Society
Kennestone Hospital, Marietta
The Medical Center, Columbus
Memorial Medical Center, Savannah
Metropolitan Hospital, Atlanta
Northeast Georgia Medical Center, Gainesville
Northside Hospital, Atlanta
Phoebe Putney Memorial Hospital, Albany
Piedmont Hospital, Atlanta
St. Joseph's Hospital, Atlanta
Scottish Rite Hospital, Atlanta
South Fulton Hospital, Atlanta
South Georgia Medical Center, Valdosta
Sumter Regional Hospital, Americus

University Hospital, Augusta
VA Medical Center, Dublin
West Paces Ferry Hospital, Atlanta

*Joint Sponsorship*

From time to time our Committee is asked to authorize Category 1 AMA continuing medical education credit for CME meetings planned by various organizations. To deal with these requests, our Committee developed guidelines for cosponsorship of CME activities. Reflecting the essential rule of the national Accreditation Council for Continuing Medical Education, we will authorize no Category 1 credit for a medical meeting unless we have been given a chance to participate in the program planning. We informed the state's medical community of our guidelines with an announcement in the MAG *Newsletter,* in September of last year.

In the past year, we have reviewed over a dozen applications for joint sponsorship, and have agreed to cosponsor the following CME activities:

1) Impaired Health Professional Program, April 3-6, 1986: 10th Annual Caduceus Club Retreat
2) St. Joseph's Hospital, Savannah, April 5, 1986: "Office Orthopedics"
3) Mercer University School of Medicine, May 8, 1986: "Computers in Medicine"
4) Decatur Hospital, March 7, 1987: "A Day of Addictive Disease"
5) MAG-MAG Mutual "Good Practice Policies" Seminars, Atlanta, March 18-19 and 25-26, 1987
6) DHR Community Health Section Conference, September 27-30, 1987

*ACCME Inspection*

MAG is authorized to accredit *intra*state providers of CME, such as Georgia specialty societies and hospitals, by the Accreditation Council for Continuing Medical Education (ACCME). In 1985 the ACCME began the process of surveying each state medical association to determine whether its procedures for intrastate accreditation were in conformity with the national guidelines for CME, which are the ACCME "Essentials."

Last fall two ACCME surveyors came to Georgia to conduct their survey of our Committee's accreditation work. We have already been informally notified that MAG will be recertified by the ACCME as an accreditor, but we won't have the formal ACCME evaluation report until later this year.

*Georgia Physicians' Participation in CME: A Recommendation*

Spurred by increasing interest in other states of a *mandatory* requirement for physician participation in CME, the Committee determined to attempt to gauge Georgia physicians' level of voluntary participation in CME. As an alternative to a costly all-physician survey, we decided to ask all 37 accredited CME providers in the state to inform us on the numbers of physicians to whom they have authorized Category 1 credit, and how many total credit hours had been issued to those physicians.

Responses have been encouraging, and we have begun to analyze the information received. At the same time, we recognize that the only sure way to determine every physician's participation in CME is to ask each one.

We believe that one effective means to do this will be to have the Composite State Medical Board add appropriate questions to physicians' annual license renewal form. One to three questions could help both MAG and the Composite Board learn how many Georgia physicians are participating in continuing medical education, also the extent of their participation. This will be valuable information, especially if the Board wishes to consider, in the coming years, some mandated minimum CME requirement for licensure. For this reason we have proposed to the House the appended recommendation.

*Mandatory CME in Georgia?*

We have become aware that a number of state medical licensing boards across the country have begun to adopt a minimum CME requirement as a condition of relicensure. This trend represents a reversal of what we have seen in the past several years, when interest in mandatory CME began to wane after, say, 1977. More important, we have been told that next year, when the Composite State Board of Medical Examiners comes up for legislative sunset review, the Georgia General Assembly will likely consider enacting a mandatory minimum requirement of continuing medical education for physicians in our state.

MAG's position on this issue was adopted by the House of Delegates in 1979, when we voted against mandatory CME, and encouraged physicians to participate voluntarily in programs designed "to maintain professional knowledge and ability through education."

We believe that MAG, in anticipation of next year's legislature, should review this statement and determine its continued feasibility. See our second recommendation.

As Chairman, I am indebted to the membership of my Committee — an impressive group of energetic physicians who are committed to ensuring for the Medical Association of Georgia an influential role in continuing medical education. They are: J. Paul Ferguson, Rome; John A. Harrel, Jr., Decatur; John A. Hudson, Macon; James A. Maughon, Atlanta; Peter L. Meehan, Atlanta; Victor A. Moore, Augusta; Hillary R. Newland, Athens; Neil G. Perkinson, Atlanta; Carl L. Rosengart, Savannah; William E. Silver, Atlanta; Barry D. Silverman, Atlanta; Rodney L. Smith, Gainesville; Roland S. Summers, Savannah; Charles R. Underwood, Marietta; and William H. Whaley, Atlanta.

**Recommendation**

1) The Medical Association of Georgia should work with the

Composite State Board of Medical Examiners to add questions to the physicians' annual license renewal form in order to ascertain Georgia physicians' participation in continuing medical education.

2) The Medical Association of Georgia should review its "Statement on Continuing Medical Education," as adopted by the House of Delegates in 1979, and determine its continued feasibility; such a review should be conducted by the Committee on Continuing Medical Education with a report to the Board of Directors later this year.

**House Action**

*Recommendation 1:* Adopted as amended:

*The Medical Association of Georgia should work with the Composite State Board of Medical Examiners to ascertain Georgia physicians' participation in continuing medical education.*

*Recommendation 2:* Adopted.

## Resolution 13

## Funding for Medical Students

### Bibb County Medical Society

RESOLVED, that the Medical Association of Georgia encourage participation of medical students from each of the medical schools in Georgia by increasing its funding of meeting and transportation expenses to a level adequate to support two representatives from each school to the annual meetings of the Medical Association of Georgia and the American Medical Association.

**House Action**

Adopted.

## Resolution 29

## Drug Free Schools

### Medical Association of Atlanta

RESOLVED, that the Medical Association of Georgia, through each component society, find and identify by name an interested and capable physician to assist local school systems to serve on an advisory panel; such list to be obtained and made available to the Coordinator of Health and Physician Education for the State Department of Education by May 15, 1987.

**House Action**

Adopted as amended:

*That the Medical Association of Georgia, through each component society, nominate an interested and capable physician to assist local school systems to serve on an advisory panel; such list to be obtained and made available to the Coordinator of Health and Physical Education for the State Department of Education by May 15, 1987.*

## Resolution 30

## Drug Free Schools and Communities Act of 1986/Georgia Implementation Organized Medicine Encouragement and Assistance

### Medical Association of Atlanta

RESOLVED, that the MAG via each component society:

1) encourage each school district in Georgia to participate in the drug free schools and communities program, and
2) each component society make available to school districts in their area the tools of drug testing required to more fully utilize the program (Cobb County model).

**House Action**

Adopted.

## Resolution 35

## Communications to MAG Members

### Georgia Medical Society

RESOLVED, that the Medical Association of Georgia develop for its officers, key members and local societies and any member who desires to participate, an appropriate on line computer system for transmitting information.

**House Actioin**

Adopted as amended:

*That the Medical Association of Georgia investigate the feasibility of developing for its officers, key members, and local societies and any member who desires to participate, an appropriate on-line computer system for transmitting information.*

Research works.

American Heart Association

# REPORT
# Reference Committee
# F

*PRESIDENT of the Medical Association of Atlanta, Gwynne Brunt welcomes the MAG House of Delegates to Atlanta. Dr. Brunt also served as chairman of Reference Committee F.*

*Reference Committee F was comprised of the following physicians: Gwynne T. Brunt, Chairman, Atlanta; Luther M. Thomas, Jr., Vice Chairman, Augusta; Irving Hellenga, Toccoa; John I. Dickinson, Rome; C. Emory Johnson, Jr., Macon; Robert D. Gongaware, Savannah; Marvyn D. Cohen, Columbus; Frank F. Middleton, III, Albany; and Jeffrey T. Nugent, Atlanta.*

## Treasurer

**Cyler D. Garner, M.D.**

In my Treasurer's Report for the past two years I have stressed MAG's progress toward achieving organizational goals. In this regard, I believe we cannot overemphasize the importance of a strong financial base upon which to assure your Association's ability to fulfill membership needs.

When I took office in 1984, we came within days of having to borrow funds to meet day-to-day expenses. Under these conditions, a medical association cannot operate in the best interest of its membership. Considering how rapidly our environment changes, MAG must be able to respond quickly to protect those aspects of medical care to which we are dedicated.

Fortunately, in the last three years, your Association has accomplished the goal of rebuilding cash reserves to a level sufficient to maintain regular operations and to expand into new areas of importance. This year's financial projections for regular operations yield an Excess of Revenue over Expense of some $78,000. This year's performance exceeds the budgeted surplus by almost $60,000. In fact, this is the third year of positive financial results following several years which severely depleted MAG's cash reserves.

Last year we were able to "hold the line" and avoid a dues increase. I am happy to report that once again recommendations for fiscal year 1988 propose a balanced budget *without* a dues increase. I think this clearly demonstrates to the membership that we are expending funds prudently, where needed and cost effectively.

I wish to thank the membership which paid $900,000 in assess-

ments for our tort reform educational activities. While we did not raise as much as the Trial Lawyers, our educational activities led to significant legislation which will assure access to quality care for our Georgia patients. This year we expended roughly half of the funds collected. The unspent balance will be reserved to ensure your assessments are used to enhance and protect recent legislation.

The legislation passed during the 1987 General Assembly is a successful first step, but only a first step. During the next few years we will move to enhance this year's accomplishments to assure that you can continue to practice medicine for the good of your patients.

In the past I have talked at length about the more routine aspects of MAG operations — printing, data processing and the like. We will continue to monitor these expenditures closely so as not to waste money which can be better utilized elsewhere.

For example, data processing expenditures in fiscal year 1985 were approximately $351,000. The proposed budget for FY 1988 is $207,000 and includes expenditures for handling computer requirements of the Georgia Health Network. These savings can be used to minimize dues or to provide new services.

I would like to point out that no organization is better than the employees who perform the day-by-day tasks. I would like to offer thanks to MAG's staff and to Michael Fowler and Hoyt Torras for their support in achieving our objectives.

The Finance Committee's recommendation for the FY 1988 Regular Operating Budget proposes a surplus of $1,324. Obviously, this is an extremely tight budget. In the past, with low cash reserves, such ambitious budget proposals would require a dues increase. However, we have avoided an increase; but we will have to work diligently to meet this objective.

Your leadership recognizes that MAG's accomplishments are due to the support of our growing membership. I wish to express my appreciation for this support and pledge to continue the momentum developed over the last three years. Working together, 6,500 MAG members can accomplish what is best for Georgia physicians and our patients.

*EDWARD WAITS, JR., a general surgeon in Atlanta and Chairman of MAG's Impaired Physicians Committee, spoke to the Auxiliary about the disease of chemical dependence and the role of the spouse in a physician's recovery.*

## Impaired Physicians Committee

**Edward J. Waits, M.D., Chairman**

The Committee held three regular meetings and one called meeting during the calendar year.

New members of the Committee were indoctrinated as to purpose and the goals of the Committee, i.e., education in regard to physician impairment, identification of impaired physicians, techniques of intervention, various modalities and options of treatment, problems associated with reentry, aftercare and relapse.

The Annual Advocacy Workshop was held in April for the purpose of enlisting MAG members and Auxilians to become advocates of our program and of those in the program. The participation of the Auxiliary in this program was a welcomed addition. This workshop will continue as an annual event.

Your Committee Chairman and several Committee members presented programs on physician impairment and family involvement at several local societies for physicians and spouses.

The accomplishments of the Medical Association of Georgia's Impaired Physicians Program for the year 1986 can be summarized as follows:

The Medical Association of Georgia's Impaired Physicians Program continues to be recognized as the leading program in the nation, evidenced in the year 1986-87 by:

1. Acceptance by the *Journal of the American Medical Association (JAMA)* of an article to be published in June of the characterization of 1,000 impaired physicians. This is in excess of all previous total im-

paired physicians reported in the entire English literature.

2. Presentation of the AMA-ERF award to Dr. G. Douglas Talbott and Dr. Donald Keith at the interim meeting of the AMA in Las Vegas in December. Dr. Talbott's award was accepted by Dr. Watson.

3. The first meeting of the ten state Impaired Physicians Program (P.I.P.E.S.S.) convened by the AMA in Atlanta, utilizing MAG's computer program and based on MAG's Impaired Physicians Program.

4. The identification, intervention and treatment of 236 Georgia physicians which continues to show a high identification rate into the total Georgia physician population. This insures quality control of medicine in Georgia and insures MAG's continuation as a national model.

5. Continuation of an active program with the Georgia Medical Auxiliary. Dr. Waits, Dr. Talbott and Dr. Browne are traveling throughout the state of Georgia to talk with the various Auxiliary chapters.

*Financing the MAG Impaired Physicians Program*

Paramount has been the concern for long-term and permanent financing of the Medical Association of Georgia's Impaired Physicians Program. This entails the employment of a full-time medical director housed at the Medical Association of Georgia's headquarters under the direction of Mike Fowler. Initially the eight treatment centers approved by the Board of Medical Examiners for treatment of impaired physicians were approached for funding this program. However, no consensus of funding was approved by the treatment centers for the necessary $150,000 to implement the program in addition to the $50,000 provided by the Medical Association of Georgia. The fact that one or two of the treatment centers were willing to participate would have defeated this effort because it would have appeared to have captured the medical director in a marketing trap for those treatment centers.

The Impaired Physicians Committee by vote of its members believes the best way to finance an enhanced program with a full time medical director would be under contract with the Composite Board of Medical Examiners following an increase in the licensure fee of $12.50 per year ($25 for a two year license renewal).

*Recommendations*

1. That Medical Association of Georgia support the concept of a fulltime medical director, who would be an MAG staff employee with an office in the MAG headquarters building; and

2. That Medical Association of Georgia support a $25 biennial increase in the medical licensure fee provided appropriate determination is made that the proceeds will make possible a mutually acceptable contract for the implementation of the Impaired Physicians Program; and

3. That the Medical Association of Georgia continue its support of $50,000 per year as the base funding necessary to support one-fourth (¼) of the budget required for a fulltime Medical Director headquartered at the MAG building. This base support is necessary for MAG to continue to control and lead the program.

4. That Medical Association of Georgia give strong support to accomplish the objectives in Recommendations one and two above.

**House Action**

See House Action on Budget Recommendation IV of the MAG Board of Directors elsewhere in the Report of Reference Committee F.

## Public Relations Committee

**Jeffrey T. Nugent, M.D., Chairman**

*Referred to:* Recommendation 1 — Reference Committee C, Recommendation 2 — Reference Committee A/F.

*Editorial Note: The report of the Public Relations Committee appears in its entirety in the Report of Reference Committee A.*

MAG's Public Relations Committee met five times during this past year. The Chairman wishes to thank the following members of the Public Relations Committee, who have unselfishly given a great deal of their time and efforts to these projects during the past year: Kathy Easterling, M.D., James G. Killebrew, Jr., M.D., Thomas A. Lyons, M.D., Charles W. McDowell, Jr., M.D., Christian R. Moorhead, M.D., Toby S. Morgan, M.D., Alan Pomerance, M.D., Beverly B. Sanders, Jr., M.D., Gerald Stapleton, M.D., Joseph W. Stubbs, M.D., Mrs. William C. Tippins, Jr., William Weston, M.D. and Edgar Woody, M.D.

**Recommendations**

1. The Public Relations Committee recommends that the remainder of the unspent funds from the 1986 assessment of membership for a Public Education Campaign for Tort Reform be maintained in a separate account for a continued effort in 1987 and 1988 to further obtain key Tort Reform Legislation, which was not passed by the Georgia Legislature in 1987. Particularly important to us is a limitation on pain and suffering awards, structured settlements, attorney contingency fee regulation, and any other elements of Senate Bills 1 and 2, which were not passed by the Legislature.

2. We request a $50,000 budget for 1987-88 for two purposes: primarily to continue with the program co-sponsored with the MAG Auxiliary entitled "You Can Say No," Teenage Pregnancy Prevention Campaign, and secondly to develop a Public Education Campaign concerning the responsibility of the citizens of Georgia to take charge of their own preventive health lifestyle practices, develop price consciousness in the purchase of health services, and promote understanding of the elements of quality health care.

### House Action

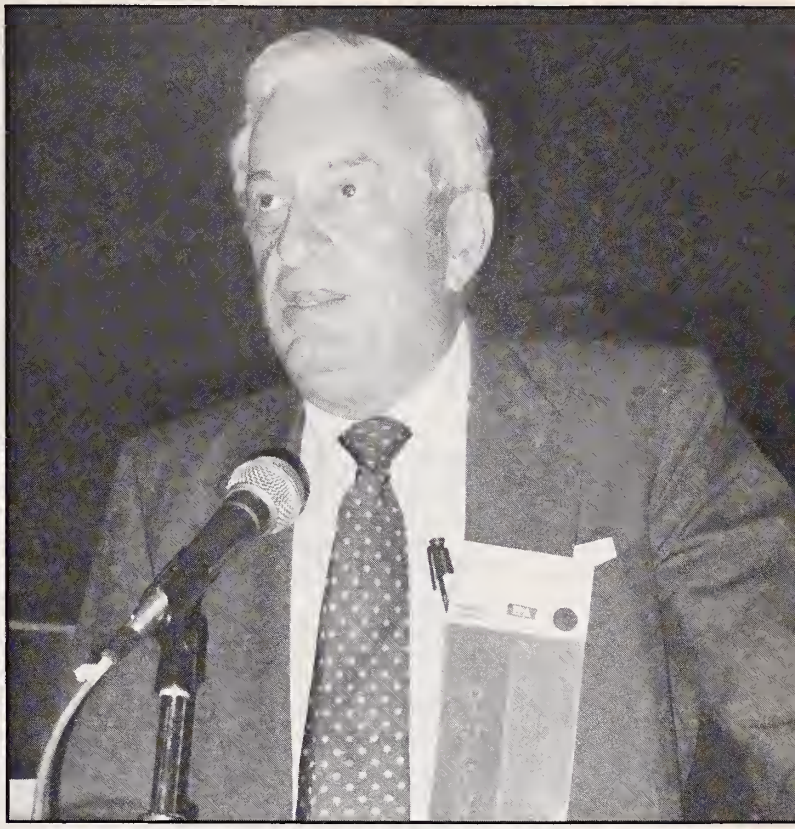
*Recommendation 1:* See House Action on Budget Recommendation II of MAG Board of Directors elsewhere in this Report of Reference Committee F.

*Recommendation 2:* Adopted as amended to read:

*Funding for the Public Relations Committee be established at $50,000 primarily for two purposes: Continuation of the program co-sponsored with the MAG Auxiliary entitled "You Can Say No," Teenage Pregnancy Campaign, and to develop a Public Education Campaign advocating the adoption of preventive health lifestyle practices.*

*WILLIAM C. COLLINS, Delegate from M.A.A. and Chairman of MAG's Board of Directors, and James A. Kaufmann, Speaker of the House.*

*CARL V. HANCOCK, Delegate from Dougherty County Medical Society.*



*J. HAROLD HARRISON, member of MAG's Board of Directors and Delegate from the Medical Association of Atlanta.*

*JAMES H. SULLIVAN, Delegate from Muscogee County and Chairman of the Credentials Committee.*

*IRVING D. HELLENGA, a family physician and Delegate from Stephens-Rabun Medical Society.*

## Chairman of the Board of Directors

**William C. Collins, M.D.**

What follows is the Fiscal Year 1987-1988 MAG budget as recommended by the Board of Directors:

### MAG BUDGET SUMMARY

| *Category* | *Projected Results May 31, 1987* | *FY 1987 Budget* | *1988 Recommended Budget* |
|---|---|---|---|
| **Revenue** | | | |
| Dues Revenue | $1,705,000 | $1,739,300 | $1,730,000 |
| Risk Management | 41,000 | 10,000 | 15,000 |
| Advertising Revenue | 110,000 | 132,000 | 120,000 |
| Scientific Assembly | 0 | 0 | 40,000 |
| Leadership Conference | 18,200 | 17,500 | 17,500 |
| *Journal* Subscriptions | 4,500 | 6,500 | 5,000 |
| AMA Refund | 7,800 | 8,000 | 8,500 |
| Data Processing | 80,000 | 80,000 | 80,000 |
| Interest Income | 110,000 | 110,000 | 125,000 |
| Rental Income | 33,000 | 34,000 | 33,000 |
| Miscellaneous Income | 38,000 | 37,000 | 30,000 |
| **Total Revenue From Regular Operations** | $2,147,500 | $2,174,300 | $2,204,000 |
| **Expenditure Summary** | | | |
| Administration | $1,004,133 | $1,020,519 | $1,045,769 |
| Membership Services | 135,010 | 142,865 | 163,615 |
| Building | 176,385 | 185,865 | 182,300 |
| *Journal* | 177,495 | 173,274 | 187,009 |
| Data Processing | 229,301 | 254,013 | 206,347 |
| Other | 3,600 | 3,600 | 3,600 |
| Board Contingent | 25,000 | 50,000 | 20,000 |
| Committees | 318,066 | 333,464 | 394,036 |
| **Total Expenditures Regular Operations** | $2,068,990 | $2,163,600 | $2,202,676 |
| Revenue Over Expense Regular Operations | $ 78,510 | $ 10,700 | $ 1,324 |

### Administration

| *Category* | *Projected Expenditures May 31, 1987* | *FY 1987 Budget* | *1988 Recommended Budget* |
|---|---|---|---|
| Salaries | $ 659,220 | $ 661,082 | $ 687,060 |
| Health Insurance | 39,000 | 39,200 | 43,500 |
| Disability Insurance | 4,500 | 4,350 | 5,016 |
| FICA Tax | 38,600 | 41,257 | 39,943 |
| Unemployment — State | 1,386 | 1,400 | 1,450 |
| Unemployment — Federal | 1,232 | 1,530 | 1,300 |
| Retirement | 44,775 | 44,980 | 51,600 |
| Recruitment | 9,000 | 300 | 300 |
| Legal Fees | 14,000 | 10,000 | 15,000 |
| Telephone | 46,320 | 44,000 | 48,500 |
| Postage | 40,700 | 44,400 | 44,400 |
| Staff Travel | 29,650 | 27,820 | 30,000 |
| Printing | 2,300 | 2,500 | 2,500 |
| Dues & Subscriptions | 2,250 | 2,200 | 2,400 |
| Audit | 19,000 | 15,000 | 20,000 |
| Xerox Maintenance | 13,000 | 13,500 | 13,900 |
| Retirement Trust Fee | 4,500 | 4,500 | 4,500 |
| Equipment Maintenance | 8,900 | 11,500 | 8,400 |
| Temporary Help | 3,300 | 3,500 | 3,500 |
| D&O Coverage | 0 | 30,000 | 0 |
| Office Supplies | 22,500 | 17,500 | 22,500 |
| **Total — Administration** | $1,004,133 | $1,020,519 | $1,045,769 |

**Building**

| Category | Projected Expenditures May 31, 1987 | FY 1987 Budget | 1988 Recommended Budget |
|---|---|---|---|
| Building Maintenance | $ 11,000 | $ 13,000 | $ 11,500 |
| Janitorial Service | 16,500 | 18,000 | 17,000 |
| Insurance | 8,200 | 8,800 | 8,800 |
| Utilities | 42,600 | 43,065 | 43,500 |
| Depreciation — Building | 33,000 | 37,500 | 33,000 |
| Depreciation — Equipment | 39,000 | 39,500 | 39,500 |
| Ad Valorem Tax | 26,085 | 26,000 | 29,000 |
| **Total — Building** | $ 176,385 | $ 185,865 | $ 182,300 |

**Membership**

| Category | Projected Expenditures May 31, 1987 | FY 1987 Budget | 1988 Recommended Budget |
|---|---|---|---|
| Travel — President | $ 5,000 | $ 5,000 | $ 7,000 |
| Travel — President Elect | 4,000 | 4,000 | 4,000 |
| Travel — Past President | 1,750 | 1,750 | 3,000 |
| Travel — AMA Delegates | 35,600 | 40,000 | 35,000 |
| Caucus Breakfast | 2,600 | 2,600 | 2,600 |
| Headquarters Suite | 6,000 | 5,000 | 10,000 |
| Southeastern Coalition | 3,800 | 2,800 | 4,000 |
| Travel— Sec & Treas to AMA | 3,560 | 5,600 | 3,500 |
| Two MD's AMA Leadership | 1,600 | 1,600 | 1,600 |
| AMA — Medical Student Sec | 2,700 | 3,840 | 2,740 |
| State Med Ed Luncheon | 350 | 375 | 375 |
| Sundry | 550 | 600 | 600 |
| Exec Comm Provisional | 2,000 | 6,000 | 6,000 |
| Exec Comm Travel | 7,800 | 8,700 | 8,700 |
| Business Coalition | 4,000 | 4,000 | 4,000 |
| Meetings | 10,500 | 10,000 | 11,000 |
| Pres Provisional Fund | 24,000 | 24,000 | 24,000 |
| Pres Executive Fund | 0 | 0 | 16,000 |
| Roster | 16,200 | 14,000 | 16,500 |
| Proceedings Issue | 3,000 | 3,000 | 3,000 |
| **Total — Membership** | $ 135,010 | $ 142,865 | $ 163,615 |

***Journal***

| Category | Projected Expenditures May 31, 1987 | FY 1987 Budget | 1988 Recommended Budget |
|---|---|---|---|
| Salaries | $ 44,800 | $ 41,479 | $ 46,750 |
| Health Insurance | 5,725 | 4,017 | 6,026 |
| FICA | 2,945 | 3,035 | 3,343 |
| Retirement | 2,800 | 2,918 | 2,940 |
| Printing | 100,500 | 102,400 | 105,000 |
| Photo Processing | 500 | 500 | 500 |
| Advertising Promotion | 100 | 100 | 500 |
| Postage | 12,250 | 10,120 | 13,000 |
| Clipping Service | 400 | 480 | 450 |
| Dues & Subscriptions | 275 | 225 | 300 |
| Artwork | 5,200 | 6,000 | 6,000 |
| Travel | 2,000 | 2,000 | 2,200 |
| **Total — *Journal*** | $ 177,495 | $ 173,274 | $ 187,009 |

**Other**

| Category | Projected Expenditures May 31, 1987 | FY 1987 Budget | 1988 Recommended Budget |
|---|---|---|---|
| Franklin Benefits | $ 3,600 | $ 3,600 | $ 3,600 |
| Board Contingent | 25,000 | 50,000 | 20,000 |
| **Total — Other** | $ 28,600 | $ 53,600 | $ 23,600 |

**Data Processing**

| Category | Projected Expenditures May 31, 1987 | FY 1987 Budget | 1988 Recommended Budget |
|---|---|---|---|
| Salaries | $ 82,000 | $ 82,106 | $ 71,500 |
| FICA | 5,863 | 5,870 | 5,112 |
| Health Insurance | 4,930 | 4,760 | 5,800 |
| Disability Insurance | 540 | 820 | 590 |
| Retirement | 4,632 | 5,700 | 5,720 |
| Unemployment — State | 252 | 297 | 190 |
| Unemployment — Federal | 224 | 345 | 170 |
| Insurance | 1,350 | 1,350 | 1,450 |
| Equipment Rental | 3,200 | 4,200 | 2,000 |
| Equipment Maintenance | 34,850 | 33,000 | 29,000 |
| Data Communication | 700 | 815 | 815 |
| Supplies — Durable | 1,250 | 1,500 | 6,000 |
| Supplies — Expendable | 8,960 | 12,000 | 1,500 |
| Depreciation/Amort | 58,000 | 73,000 | 59,000 |
| Travel | 2,100 | 2,500 | 2,000 |
| Education & Dues | 0 | 500 | 300 |
| Consulting Fees | 10,200 | 11,000 | 5,000 |
| Temporary Help | 0 | 0 | 0 |
| Recruitment | 0 | 200 | 0 |
| Office Operations | 7,350 | 7,500 | 7,800 |
| Software Documentation | 2,900 | 6,550 | 2,400 |
| **Total — Data Processing** | $ 229,301 | $ 254,013 | $ 206,347 |

**Committees**

| Category | Projected Expenditures May 31, 1987 | FY 1987 Budget | 1988 Recommended Budget |
|---|---|---|---|
| Access to Health Care | $ 2,900 | $ 5,000 | $ 3,500 |
| Annual Session | 28,000 | 22,000 | 36,000 |
| Auxiliary | 59,000 | 63,549 | 63,549 |
| Cost Awareness | 0 | 1,000 | 0 |
| Doctor-of-Day | 5,500 | 5,500 | 6,300 |
| Impaired Physicians | 50,000 | 50,000 | 50,000 |
| Legislation & Bulletin | 59,150 | 65,000 | 62,812 |
| PIP | 6,200 | 4,900 | 8,915 |
| Education | 2,300 | 2,875 | 2,375 |
| Medical Aspects of Sports | 716 | 1,300 | 1,500 |
| Nutrition | 0 | 500 | 0 |
| Physician-Lawyer Liaison | 4,200 | 7,500 | 5,000 |
| Membership Insurance | 0 | 1,500 | 1,500 |
| Public Relations | 50,000 | 50,000 | 50,000 |
| Scientific Assembly | 0 | 0 | 40,000 |
| Newsletter | 17,500 | 16,000 | 19,000 |
| Third Party Relations | 1,000 | 1,500 | 2,500 |
| Leadership Conference | 22,800 | 17,500 | 17,500 |
| Computers In Medicine | 600 | 1,000 | 1,000 |
| Resident Physician Proj | 7,100 | 7,840 | 4,130 |
| Public Health | 100 | 3,000 | 3,000 |
| Medical Schools | 0 | 1,000 | 1,000 |
| Membership | 1,600 | 5,000 | 3,000 |
| Medical Practice | 0 | 0 | 1,500 |
| Hospital Medical Staff | 0 | 0 | 5,000 |
| Committee On Disadvantaged | 0 | 0 | 3,000 |
| Prof Liability Support | 0 | 0 | 1,955 |
| **Total — Committees** | $ 318,666 | $ 333,464 | $ 394,036 |

**Tort Reform**

| *Category* | *Projected Results May 31, 1987* |
|---|---|
| Assessment Collections | $ 900,000 |
| **Expenditures** | |
| Staff Allocation | $ 76,000 |
| Telephone | 18,000 |
| Postage | 37,000 |
| Travel | 4,500 |
| Printing & Supplies | 23,000 |
| News Clipping | 9,500 |
| Consulting & "Survival Kit" Production | 251,000 |
| Miscellaneous | 12,500 |
| **Total Projected Expenditures** | $ 431,500 |
| **Tort Reform Excess to Reserves** | $ 468,500 |

**Budget Recommendations**

I. In view of MAG's strong financial position, a dues increase should *not* be required during FY 1988.

II. Unobligated funds from the Tort Reform Assessment remaining as of May 31, 1987 should be reserved and spent as needed in subsequent years to enhance and protect efforts regarding professional liability. Such expenditures will be budgeted and approved by the MAG Executive Committee. This reserve fund will be handled in the same manner as the Building Reserve.

III. In recognition of increased demands placed upon the President of the Association, it is recommended that a new budget item — PRESIDENT'S EXECUTIVE FUND ($16,000) — be established to help defray expenses of the office.

IV. It is recommended that $50,000 be provided to fund the Impaired Physicians Program as requested.

V. It is recommended to study further a request from the Crawford W. Long Museum Foundation for a $40,000 grant to fund renovations to the museum. Currently, MAG's members provide approximately $14,500 annually through voluntary contributions when paying MAG dues. The Finance Committee suggested MAG offer help in soliciting grants from other sources such as drug companies producing anesthetics.

VI. It is recommended that 20,000 be budgeted for Board Contingency as reasonably anticipated expenditures.

VII. The recommended budget as attached provides an EXCESS OF REVENUE OVER EXPENSES from REGULAR OPERATIONS of $1,324.

**House Actions**

*Recommendation I:* Adopted.

*Recommendation II:* Adopted as amended to read:

*"Unobligated funds from the Tort Reform Assessment remaining as of May 31, 1987 should be reserved and spent as needed in subsequent years to enhance and protect efforts regarding professional liability. Such expenditures will be budgeted and approved by the MAG Executive Committee. This reserve fund will be handled in the same manner as the Building Reserve Account. No portion of staff salaries performing tort reform activities should be charged to the Tort Reform Reserve Account."*

*Recommendation III:* Adopted.

*Recommendation IV:* Adopted as amended to read:

*"Funding of $50,000 for the Impaired Physicians Program should be provided for this year as requested. In addition, the formation of an Ad Hoc Committee of the Board of Directors to evaluate the*

*continuation and direction of this program is recommended. A report of the findings of this Ad Hoc Committee shall be presented at the September meeting of the Board of Directors concerning the following matters:*

*a) The need for a permanent overview committee to evaluate the on-going Impaired Physicians Program;*
*b) The need for program enhancements including employment of a full-time Medical Director;*
*c) Other possible sources of funding including designating a portion of physician licensure fees, payments and/or donations by institutions treating impaired physicians, and solicitation of voluntary contributions;*
*d) The finances of the entire Program* including *those of all related organizations such as the Cadeceus Foundation; and*
*e) Any and all other matters affecting the continued operation, direction and management of this worthwhile program."*

*Recommendation V:* Adopted.

*Recommendation VI:* Adopted as amended to read:

*"Funding for Board Contingency be increased by $20,000 to $40,000."*

*Recommendation VII:* Adopted as amended to read:

*"Decrease Dues Revenue by $25,000 to $1,705,000;*

*"Decrease Risk Management Revenue by $5,000 to $10,000;*

*"Decrease Total Revenue from Regular Operations by $30,000 to $2,174,000;*

*"Increase Board Contingency by $20,000 to $40,000;*

*"Increase Salaries, Administration by $76,000 to $763,060;*

*"Increase Total-Administration by $76,000 to $1,121,769;*

*"Increase Total Expenditures Regular Operations by $96,000 to $2,298,676;*

*"Decrease Revenue Over Expense Regular Operations by $126,000 to ($124,676)."*

## Resolution 23

## Support of Impaired Physicians Program

### Muscogee County Medical Society

RESOLVED, that the Medical Association of Georgia commend its Impaired Physicians Program for the service it continues to render to its membership; and be it further

RESOLVED, that the Medical Association of Georgia continue to provide support, including reasonable financial support, to the Impaired Physicians Program, within the restraints of its resources.*

**House Action**

First Resolved: Adopted.

Second Resolved: See House Action on Budget Recommendation IV, of the MAG Board of Directors elsewhere in this Report of Reference Committee F.

* *Fiscal Note:* $50,000 requested by the Impaired Physicians Committee

# REPORT
# Reference Committee
# C & B

*(R) JAMES Q. WHITAKER, from Peachbelt County Medical Society, chaired the Reference Committee on Constitution and Bylaws, ably assisted by MAG staff James M. Moffett.*

*The Reference Committee on Constitution and Bylaws was comprised of the following physicians: James Q. Whitaker, Chairman, Warner Robins; Ellis B. Keener, Vice-Chairman, Gainesville; James O'Quinn, Augusta; Clyde B. Rountree, Decatur; Walter M. Ligon, Marietta; Alva L. Mayes, Jr., Macon; Billy D. Burk, Rome; and William A. Wolff, Columbus.*

## Membership Committee

**Ralph A. Tillman, M.D., Chairman**

The MAG Membership Committee met three times in 1986. The Committee concentrated its efforts in two major areas: (1) Retaining current MAG members and (2) Recruiting new members.

In the area of retaining current MAG members, a new brochure entitled, "How Can We Serve *You* Better?," was developed by the membership committee. This brochure was sent to MAG members who were delinquent in paying their 1986 dues to determine why they had not paid these dues.

Their answers varied: 36% of the respondents said it was an oversight and they would pay their dues; 19% felt that MAG or their County Medical Society did not have anything to offer them or that membership benefits were not worth the expense of dues; 15% said they were not financially able to pay dues; 9% said they had no further interest in MAG; 6% said their health kept them from actively participating in organized medicine; 6% said they did not have the time to participate in organized medicine; 3% said their specialty society needed them more; and the remaining 6% did not answer the questions but made additional comments. The Membership Committee has discovered a need for all member's assistance in helping MAG gain new members and is therefore reviewing the above data and developing an appropriate physician to physician recruitment campaign.

In area of recruiting new members, the committee has been seeking the most effective ways to identify potential members. The committee determined that the three most effective ways to do this is to get the names from: The Composite State Board of Medical Examiners, the AMA, and MAG's Composite County Medical Societies. Steps are also being taken to categorize MAG's nonmember computer file so that potential members can be more readily identified. The committee is also looking at ways to recruit these potential members once they are identified.

208 new members joined MAG last year bringing the Association's membership up to 6,511 as of February 28, 1987. In the upcoming year the MAG Membership Committee will develop and implant strategic planning to recruit more nonmembers.

### Recommendation

That the MAG establish a Young Physicians Section in order to increase membership and participation in our Association among those Georgia physicians who are under 40 or within their first five years of practice.

### House Action

Filed.

## Ad Hoc Committee on Young Physicians Section

**S. William Clark, III, M.D.**

*Background and Rationale*

As the expected result of increased medical school enrollments in the 1970's, there are more young physicians in Georgia and the United States than ever. A 1983 AMA report revealed that almost 42% licensed American physicians were under the age of 40, an increase of 62% since 1970 (as compared to a 51% increase in the population of doctors over 40).

These findings led the AMA to create a Task Force on Young Physicians, which revealed a *unique set of needs* and concerns differing considerably from those of either residents or more established physicians.

In 1985, for example, 87% of U.S. medical school graduates finished school in debt, with an average indebtedness of $29,943. This may be a factor in the fact that over two-thirds of young physicians spend some time during their first year of practice as an employee.

Young physicians have also been more severely impacted by the current medical economic environment than established practitioners. In 1983 the average inflation-adjusted net income for young physicians was lower than that for their counterparts in 1970 or 1975, while the income of physicians over 40 generally exceeded the rate of inflation.

In addition, rising professional liability premiums catch young physicians at a time in which they do not have the financial security either to restrict their practice or to opt for early retirement.

*AMA Response*

Faced with these special concerns of young physicians — and especially with the fact that in last year's AMA House *only one* delegate was under the age of 40 — the AMA established a Young Physicians Section in the House of Delegates. As a result, the Section has one voting delegate and an alternate in the House, presenting concerns and resolutions developed as a result of a Section meeting held two days before each House. At our first Assembly, last December 5-7, forty-six states sent 95 young physician representatives.

*MAG's Opportunity*

The creation of the Medical Student and Resident Sections has dramatically increased the interest and participation of physicians-in-training in our state association. There are approximately 1,200 residents now training in Georgia. A possible impediment to their sustained postgraduate participation at the state level involves a bylaw which prohibits credentialing as a voting delegate until after three years of practice and membership in the MAG.

As a positive note, the MAG has a higher rate of participation by young physicians than most of our surrounding states. Current data indicate that of the 9,222 licensed practicing physicians in Georgia, 3,066 (31%) are under the age of 40. Almost two-thirds of these doctors are already MAG members. This is the same percentage as physicians over age 40. While many local factors undoubtedly influence this level of participation, the creation of the Georgia Health Network has probably influenced this increasing membership level.

The number of MAG delegates under age 40 has also risen over the past few years. While in 1982 only 6 of 215 delegates was a young physician, our count for this 1987 House shows 32 of 273 (12%) as young physicians. This figure however is still disproportionately low.

The purpose of creating a Young Physicians Section is to facilitate the "mainstreaming" of young physicians into state and national organized medicine. To some extent this is certainly already occurring in Georgia. The Young Physicians Section intends to sponsor a caucus at which all voting delegates to the MAG House under 40 years of age will be asked to attend and discuss issues of particular importance to physicians in this age range. In addition these meetings will provide an opportunity for other young physicians to appear in a forum to help identify specific areas of need and interest to this group.

It is important that MAG assure the communication of these needs and interests to our House of Delegates. Given the current Bylaws requirement that no MAG member can serve as a Delegate until after three years of practice, and the disproportionately small percentage of young physicians in the current composition of our House, we therefore propose that the MAG Constitution be amended to establish a Young Physicians Section of the MAG House of Delegates. Our specific language of amendment follows.

**Recommendations**

In compliance with the provisions of the Constitution and Bylaws, including the requirement that a constitutional amendment be introduced in the preceding session prior to House action, we the undersigned five active MAG members hereby submit the following amendments to the MAG Constitution and Bylaws for consideration at the 1988 Session:

1) *Constitution.* That ARTICLE V, SECTION 1 of the Constitution be amended adding a Young Physicians Section to the Composition of the House of Delegates so that the new Article V, Section 1 will read as follows: (new language underlined)

   Section I. Composition

   The House of Delegates is composed of delegates elected by the Component societies, <u>the Young Physicians Section,</u> the Resident Physician Section, the Medical Student Section, <u>and the</u> Hospital Medical Staff Section. All delegates' qualifications and terms of office shall be provided

for in the Bylaws. The officers, the past presidents of the Association, the Editor of the *Journal*, delegates to the AMA, the Executive Director and chairpersons of standing committees shall be ex-officio members of the House of Delegates without the right to vote.

2) *Bylaws*

That CHAPTER IV, HOUSE OF DELEGATES, SECTION 2, COMPOSITION of the Bylaws be amended by adding immediately prior to the present paragraph "The Medical Staff Section" a new paragraph to read as follows:

"The Young Physicians Section shall be entitled to one voting delegate and alternate delegate. These delegates shall be elected each year by the Section and shall be members in good standing with the Medical Association of Georgia.

3) *Bylaws*

That CHAPTER IV — HOUSE OF DELEGATES, SECTION 2 — COMPOSITION of the Bylaws be further amended by adding the words "the Young Physicians Section" of line 2 of the last paragraph of the present Section 2 so that the new last paragraph will read as follows:

"Notwithstanding any deadline established for the introduction of resolutions to the House of Delegates, the Young Physicians Section, the Medical Staff Section and the Resident Physician Section, shall have the right to adopt resolutions at their meeting immediately preceding the House of Delegates and to have their resolutions introduced at the opening session of the House.

Report and proposed amendments submitted by: S. William Clark, III, Waycross; James F. Beattie, Ft. Oglethorpe; Donald H. Campbell, Marietta; Joy A. Maxey, Atlanta; and Carol P. Motley, Columbus.

**House Action**

Recommendation 1, Constitutional amendment, was received by the House to lie on the table for one year and to be presented for a vote at the 1988 House of Delegates meeting.

Recommendation 2 was referred to Committee on Constitution and Bylaws.

Recommendation 3 was referred to Committee on Constitution and Bylaws.

## Resolution 7

## Amendment to MAG Bylaws

**Medical Association of Atlanta**

RESOLVED, that the Bylaws of the Medical Association of Georgia, Chapter V, Section 2 (a) are amended by adding the following sentence:

"Directors and Alternate Directors shall not serve more than three consecutive three-year terms."

**House Action**

Not adopted.

## Resolution 8

## Medical Student Participation in the MAG House of Delegates

**James A. Kaufmann, M.D.**

RESOLVED, that the Medical Association of Georgia Constitution and Bylaws shall be amended to provide for one voting Delegate and Alternate Delegate from the MAG Medical Student Section in the House of Delegates.

**House Action**

Not adopted.

## Resolution 25

## Medical Student Section Voting Delegate

**James A. Kaufmann, M.D.; B. Rentz Dunn, Jr., M.D.; Joy A. Maxey, M.D.; Robert J. Ollins, M.D.; and Charles R. Underwood, M.D.**

RESOLVED, that the following amendments to the MAG Bylaws be ratified by the House of Delegates:

1. Chapter IV, Section 2. Composition. Amend by striking the third paragraph of said SECTION 2 and inserting a new third paragraph to read as follows:

   *"The Medical Student Section shall be entitled to one voting delegate and alternate delegate. These delegates shall be elected each year by the Section and shall be student members in good standing with the Medical Association of Georgia."*

2. Chapter IV, Section 2. Composition. Further amend by adding the words "the Medical Student Section" immediately after the words "the Medical Staff Section" of line 2 of the last paragraph of the present said SECTION 2 so that the new last paragraph will read as follows:

   *"Notwithstanding any deadline established for the introduction of resolutions to the House of Delegates, the Medical Staff Section, the Medical Student Section* and the Resident Physician Section shall have the right to adopt resolutions at their meetings immediately preceding the House of Delegates and to have their resolutions introduced at the opening session of the House."

**House Action**

Not adopted.

## Supplemental Report of the Committee on Constitution and Bylaws

**J. Rhodes Haverty, M.D., Chairman**

The Committee on the Constitution and Bylaws hereby submits for consideration and adoption by the House an amendment to Chapter XVI, Section 1, Amendments, by changing from 75 days to 45 days the time period required for receipt of proposed amendments prior to the convening of the Annual Session at which the amendment is to be acted upon, so that Chapter XVI, Section 1 will read as follows:

"Amendments to these bylaws or to the Constitution may be proposed by action of the House of Delegates, or by the Board of Directors, or the Executive Committee of the Board of Directors, or by the Committee on Constitution and Bylaws, or by any group of active members numbering five or more. Proposed amendments must be submitted to and received by the Constitution and Bylaws Committee not less than *forty-five (45)* days prior to the Annual Session at which they are to be acted upon. In an emergency situation and upon the affirmative vote of two-thirds of the Board of Directors, a meeting of the Constitution and Bylaws Committee shall be called to consider additional amendments to the Constitution and Bylaws following the expiration of the normal amendment introduction period ending *forty-five (45)* days prior to the Annual Session."

**House Action**

Referred to Committee on Constitution and Bylaws.

## Special Recommendation of Reference Committee C&B

Directed Constitution and Bylaws Committee to develop and distribute to Delegates, Alternate Delegates, and County Medical Societies a clear, unequivocal statement on the correct procedure for proposing and introducing amendments to both the Constitution and the Bylaws.

**House Action**

Adopted.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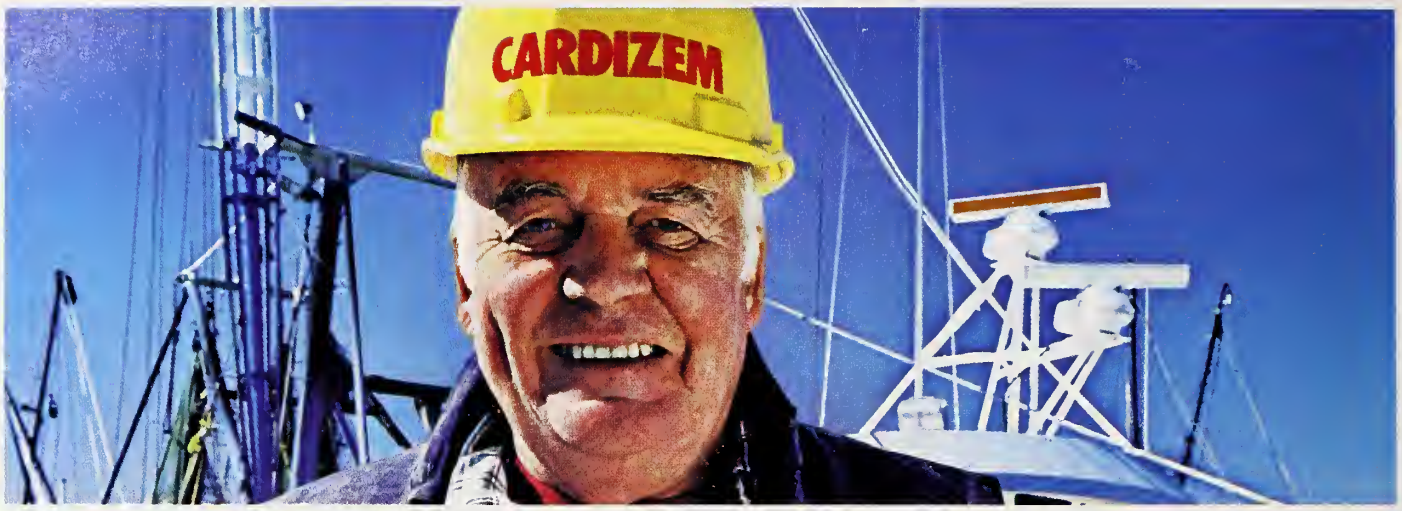


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**WARNINGS**

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

**PRECAUTIONS**

**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

**Drug Interaction.** Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

**Pediatric Use.** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS**

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

| | |
|---|---|
| Cardiovascular: | Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope. |
| Nervous System: | Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor. |
| Gastrointestinal: | Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase. |
| Dermatologic: | Petechiae, pruritus, photosensitivity, urticaria. |
| Other: | Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties. |

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

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**References: 1.** Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983; 106(6):1341-1347. **2.** Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984;24(Dec):150-159. **3.** Johnston DL, Lesoway R, Human DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687. **4.** Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. **5.** Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.

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# ADVERTISING INDEX


Air Force Reserve ..... 441

American Lung Association ..... 442, 464

Atlanta Magnetic Imaging ..... 411

Arthritis Foundation ..... 416

Burroughs Wellcome ..... 426A-B, 427

Campbell Laboratories ..... 411

Classified Ads ..... 475

CNA Insurance Companies ..... 381

CPC Parkwood ..... 410

Family Practice Recertification ..... 410

Focus: Healthcare ..... 361

Glaxo/Roche ..... 442A-D

Health Quip, Inc. ..... 361

Jaguar SS-100 ..... 474

King'sBridge ..... 416

Lilly, Eli & Company ..... 380

MAG Mutual Insurance Company ..... 360

Marion Laboratories, Inc. ..... 474A-B

M$NY Credit Corporation ..... 361

Republic Health Management ..... 474

Roche Laboratories ..... 477-478

Smith Kline & French Co. ..... 394A

United Way ..... 380

University of Alabama Medical Center ..... 378A-B, 379

Upjohn Company ..... 394B

U.S. Army ..... 362

Weight Watchers of Greater Atlanta ..... 361

Woodridge Hospital ..... 425


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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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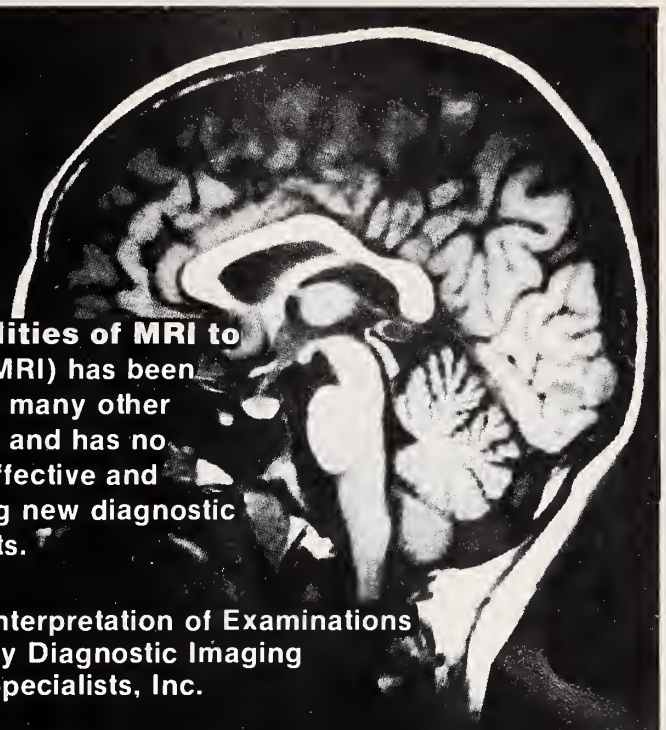

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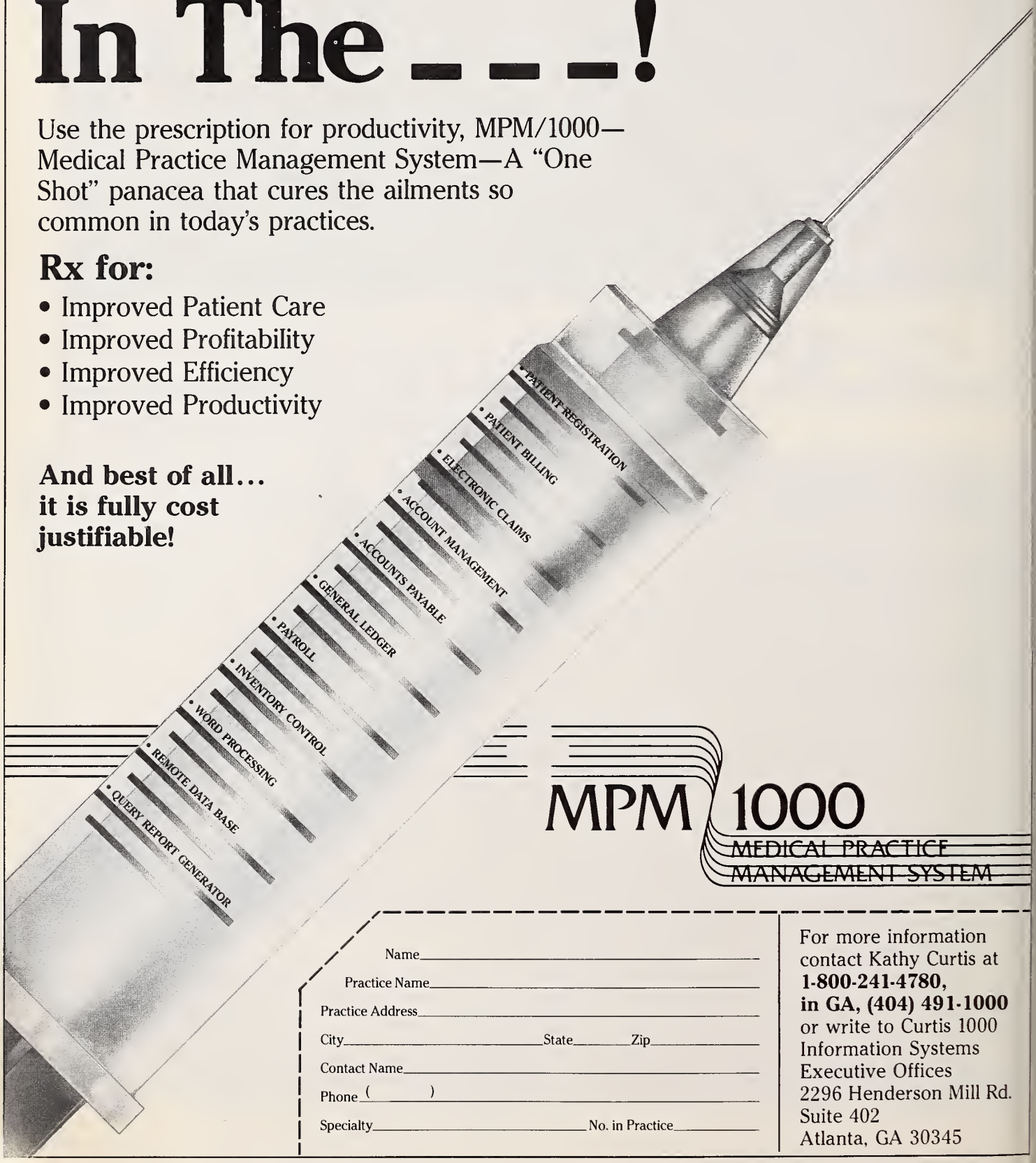


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# To show you how many hypertensives stayed on

# INDERAL® LA
(PROPRANOLOL HCl)

# after a major nationwide trial...

...we had
to find
just the
right room.

# 60,073 patients (90%) who started on INDERAL® LA stayed on INDERAL LA.[1*]

## Surprising? Not really.

Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.
A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients[2] revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol—which shows how well-tolerated once-daily INDERAL LA can be.

## Sole therapy or concomitant therapy? Fifty-nine percent of the time, INDERAL LA stood on its own.

The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were treated merely with the addition of a diuretic to INDERAL LA.

## For the noncompliant patients in your practice, INDERAL LA may well be the answer.

Almost 20,000 of the patients in the nationwide compliance trial were identified as having been noncompliant with their previous antihypertensive therapy. Their physicians reported that 88% showed improved compliance when placed on once-daily INDERAL LA.

# Control, comfort, and compliance

ONCE-DAILY
**INDERAL® LA**
(PROPRANOLOL HCl)
LONG ACTING CAPSULES

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

# The one you know best keeps looking better

NOW AVAILABLE...
NEW LOW DOSE
**INDERAL LA 60 mg**
LONG ACTING CAPSULES
(PROPRANOLOL HCl)

Please see next page for brief summary of prescribing information.

# The one you know best keeps looking better

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

**INDERAL® LA** brand of propranolol hydrochloride **(Long Acting Capsules)**

**DESCRIPTION.** INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

**CLINICAL PHARMACOLOGY.** INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

**INDICATIONS AND USAGE. Hypertension:** INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

**Angina Pectoris Due to Coronary Atherosclerosis:** INDERAL LA is indicated for the long-term management of patients with angina pectoris.

**Migraine:** INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

**Hypertrophic Subaortic Stenosis:** INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

**CONTRAINDICATIONS.** INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

**WARNINGS.** CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

**Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)**—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing $T_4$ and reverse $T_3$, and decreasing $T_3$.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

**PRECAUTIONS.** GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

*Aluminum hydroxide gel* greatly reduces intestinal absorption of propranolol.

*Ethanol* slows the rate of absorption of propranolol.

*Phenytoin, phenobarbitone,* and *rifampin* accelerate propranolol clearance.

*Chlorpromazine,* when used concomitantly with propranolol, results in increased plasma levels of both drugs.

*Antipyrine* and *lidocaine* have reduced clearance when used concomitantly with propranolol.

*Thyroxine* may result in a lower than expected $T_3$ concentration when used concomitantly with propranolol.

*Cimetidine* decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

*Theophylline* clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS.** Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

*Cardiovascular:* Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

*Central Nervous System:* Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

*Gastrointestinal:* Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

*Allergic:* Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

*Respiratory:* Bronchospasm.

*Hematologic:* Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

*Auto-Immune:* In extremely rare instances, systemic lupus erythematosus has been reported.

*Miscellaneous:* Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

**DOSAGE AND ADMINISTRATION.** INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

**ONCE-DAILY**

**INDERAL® LA**

(PROPRANOLOL HCl)

LONG ACTING CAPSULES

**REFERENCES:**


1. INDERAL LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985; 145:1321-1323.


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# CONTENTS

VOLUME 76, NUMBER 7

## FEATURES

FIRE DEATHS IN FULTON COUNTY, 1983-85 — 494
Ann Early, M.D., Randy Hanzlick, M.D.

ORGANIZED MEDICINE'S CHALLENGES TODAY: "THE GOOD, THE BAD, AND THE UGLY" — 499
James H. Sammons, M.D.

THE JOINT COMMISSION'S "AGENDA FOR CHANGE" — 503
Dennis S. O'Leary, M.D.

WHAT ABOUT THE SOCIAL SECURITY MEDICAL CONSULTANT? — 515
Bernard P Wolff, M.D., William G. Hamm, M.D.

MANAGING THE WORKLOAD IN STATE MENTAL HOSPITALS — 527
Ilhan M. Ermutlu, M.D.

## EDITORIALS

GEORGIA DOCTORS HELP MEDICALLY INDIGENT — 508
Jack F. Menendez, M.D.

FROZEN AUTOLOGOUS BLOOD — NOT GENERALLY RECOMMENDED — 510
Alfred J. Grindon, M.D., Jane B. Jennings, M.D.

OTHER HOUSES, OTHER SPEAKERS — 512
C. Emory Bohler, M.D.

## CANCER

NEOADJUVANT CHEMOTHERAPY OF CANCER — 520
Julian L. Lokey, M.D.

## HEART

ABSTRACTS FROM SYMPOSIUM ON CARDIOVASCULAR RESEARCH: PART I — 522

## DEPARTMENTS

EDITOR'S CORNER — 489
LETTERS TO THE EDITOR — 485
PRESIDENT'S PAGE — 486
ASSOCIATION NEWS — 487
CALENDAR — 484
ANABOLIC STEROIDS (MAG Medical Aspects of Sports Committee) — 498
REACH OUT AND TOUCH (Amer. Medical Assoc. of Medical Assistants) — 514
ADVERTISING INDEX/MANUSCRIPT INFORMATION — 532

## THE COVER

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# CALENDAR

## AUGUST

2-5 — *Atlanta:* **International Society for STD Research.** Category 1 credit. Contact: Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

3-8 — *Hilton Head Island, SC:* **12th Annual Your Practice, Your Money, Your Family.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

10-14 — *Atlanta:* **Summer Imaging and Interventional Techniques V.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

13-16 — *Hilton Head Island, SC:* **Ga. Psychiatric Association's Summer Meeting.** Category 1 credit. Contact James Moffett, Dir. of Specialty Society Relations, MAG, 938 Peachtree St., Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

17-21 — *Atlanta:* **A Comprehensive Board Review in Internal Medicine.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

20-23 — *Kiawah Island, SC:* **Pulmonary Disease Review.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

24-28 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

29-30 — *Callaway Gardens:* **Joint Meeting of the Ga. Society of Anesthesiologists and the Alabama Society of Anesthesiologists.** Category 1 credit. Contact Ronald W. Dunbar, M.D., Program Chairman, Dept. of Anesth., Emory Univ. Hosp., 1465 Clifton Rd., Atlanta 30322. PH:404/321-0111 ext. 3900.

## SEPTEMBER

4-6 — *Sea Island:* **Georgia Gastroenterologic Society.** Category 1 credit. Contact Steve Morris, M.D., 25 Prescott St., Atlanta. PH:404/881-1094.

4-6 — *Sea Island:* **Ga. Society of Internal Med. & Ga. Chapter, Amer. Coll. of Phys. Joint Meeting.** Category 1 credit. Contact Milton Frank, MD, GSIM, 1372 Peachtree St., Ste. 301, Atlanta 30309. PH:404/892-2131 or Mark Silverman, MD, Ga. Chapt., ACP, 1968 Peachtree Rd., Atlanta 30309. PH:404/350-3368.

17-19 — *Hilton Head Island, SC:* **9th Annual Frontiers in Nutrition.** Catefory 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

17-19 — *Sea Island:* **Georgia Surgical Society Annual Meeting.** Category 1 credit. Contact William C. McGarity, M.D., Secy.-Treas., GSS, Dept. of Surgery, 1365 Clifton Rd., Atlanta 30322. PH:404/321-0111.

17-19 — *Savannah:* **11th Annual Neonatology — The Sick Newborn.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

20-23 — *Hilton Head Island, SC:* **Georgia Obstetrical and Gynecological Society, Inc.** Contact Chester C. Lane, Executive Director, 69 Butler St., Atlanta 30303. PH:404/659-0289.

28-Oct. 2 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

## OCTOBER

1-4 — *Sea Island:* **Georgia Orthopaedic Society Annual Meeting.** Category 1 credit. Contact David F. Apple, Jr., M.D., Secy., GOS, 1938 Peachtree Rd., Ste. 710, Atlanta 30309. PH:404/352-2234.

5-10 — *Augusta:* **Obstetrics and Gynecology.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

8-9 — *Atlanta:* **Georgia Chapter, American Academy of Pediatrics Fall Meeting.** Category 1 credit. Contact William C. Mankin, Exec. Secy., Ga. Chapter, AAP, 4059 Land O'Lakes Dr., Atlanta 30342. PH:404/237-3922.

10-14 — *Atlanta:* **American Society of Anesthesiologists.** Category 1 credit. Contact AASA, 515 Busse Highway, Park Ridge, IL 60068. PH:312/825-5586.

13-16 — *Atlanta:* **American Society of Internal Medicine.** Category 1 credit. Contact Teresa Crumpler, ASIM, 1101 Vermont Ave., NW, Ste. 500, Washington, DC 20005. PH:202/289-1700.

26-30 — *Atlanta:* **American College of Chest Physicians.** Category 1 credit. Contact ACCP, 911 Busse Highway, Park Ridge, IL 30068. PH:312/698-2200.

## NOVEMBER

8-13 — *Atlanta:* **American Society of Plastic & Reconstructive Surgeons, Inc.** Category 1 credit. Contact ASPRS, 233 N. Michigan Ave., Ste. 1900, Chicago, IL 60601 PH:312/850-1818.

12-14 — *Atlanta:* **Georgia Academy of Family Physicians Annual Meeting.** Category 1 and AAFP prescribed credit. Contact GAFP, 3760 LaVista Road, Ste. #100, Tucker 30084. PH:404/321-7445.

## A Novel Approach to Informing Patients About the Liability Insurance Problem

ear Editor,

I recently discovered an excellent echanism for educating my patients out the malpractice/tort reforms/ ability insurance problem. This echanism may not be as applicable other physicians as it is to ychiatrists, but I wanted to share it ith the members of the Medical ssociation of Georgia for their nsideration.

For the past few years, I have tempted, as have many physicians, educate my patients and others out this problem. This has included aring with them the specifics of my riodic increases in liability emiums, sharing with them some the horror stories that have curred, and discussing the problem more general terms as well. Of urse, I have also just plain mplained to my patients about this oblem. None of this has helped yway near as much as the echanism that I will explain below.

I recently learned that my coming premium increase would approximately fifty percent of my 86 premium. This amounts, for e, to about a $1,688 increase over st year. It turns out that I have tually an identical number of tient visits last year, 1,685, this ing everything from a brief edication check to two hour tended family evaluations. asoning that everything from the iefest to the longest, from the nplest to the most complicated tient interaction could result in a alpractice claim, and assuming ere to be some fairness in asking y patients to share in this problem ually and among themselves, I cided to raise my rates this year by .

This may not seem significant, but erybody now asks why I am arging $96, for instance, for a one ur psychotherapy interview, compared to last year's fee of $95. By the way, this over a one year period will virtually to the dollar pay for this year's increase. Patients would have either said nothing, not cared, or complained if I had raised my rates some even amount, such as $5 or $10. Everybody is interested, curious, and appreciative that I have elected to pass this increase along in what has been seen as a very fair manner.

My patients understand it would be difficult for me to absorb the increase as a lump sum without raising my fees, are happy and not bothered to share it as I have described, and are appreciative that I pass this along equitably, rather than raising my rates to some even number.

As I indicated above, this may or may not be applicable to other professions, but I have found that this simple step has not only financed my rate increase, but it has served to educate my patients about the seriousness of this problem. At the same time, it has been a subtle message to them that in the end they are responsible for it, and hopefully at some point they collectively will do something about the liability problem in general that anyone of us is certainly unable to do.

*Yours sincerely,*
*Douglas A. Kramer, M.D.*
*Atlanta*

## Blue Cross/Blue Shield Diagnostic Testing Guidelines

I AM WRITING regarding the National Blue Cross/Blue Shield Assciation Medical Necessity Program Diagnostic Testing Guidelines which were published by the National Blue Cross/Blue Shield Association the first week in April, 1987. They were the subject of an article in the *Atlanta Constitution,* April 3, 1987, in which the article stated that these guidelines were being adopted immediately by Blue Cross/Blue Shield of Georgia, Inc. This is not true.

These guidelines will be dealt with in the same fashion as the other medical necessity issues that have come to the attention of Blue Cross/ Blue Shield of Georgia, Inc. in the past. That is, they will be referred to the Participating Physician's Council, a council of approximately 84 physicians selected by their county medical societies from across the state to provide practicing physician's input into the medical appropriateness of Blue Cross/Blue Shield's affairs. This body will refer the matter to its Medical Policy Committee. This committee will study, review, and make recommendations regarding any alterations, additions, deletions, etc. that they may think are necessary. It will then return the guidelines to the full Participating Physician's Council which will review the guidelines and forward their recommendations to the Medical Service Committee. The Medical Service Committee, which is comprised of 10 physicians and two hospital administrators, will then take the previous studies and recommendations, add their own adjustments and ultimately present the entire matter to the full Blue Cross/Blue Shield Board. Whatever part of these guidelines is ultimately accepted will be used primarily for educational overtures, and will not likely be used in specific cases, except when a pattern of practice evaluation may be warranted. Blue Cross/Blue Shield does not invoke any guidelines without adequate advance notification and information to the provider community.

Blue Cross/Blue Shield of Georgia, Inc. is an autonomous organization. It will likely need to operate in concert with all other Blue Cross/Blue Shield plans for nationally negotiated accounts. For those accounts that are sold in the State of Georgia, the vast majority of its business, Blue Cross/Blue Shield of Georgia, Inc. is responsible only to its own needs.

*Sincerely,*
*Louis H. Felder, M.D.*
*Internist, Atlanta*
*Member, MAG*
*Third Party*
*Payors Committee*

# *Becoming Involved*

*Jack F. Menendez, M.D.*

THE WORST THING that can happen to an Association such as ours is that it become inbred, directed by a few people, creating a "we and they" mentality. To the degree that there is broad based physician involvement, there is no "they."

**How Can I Become Involved?**

Perhaps that caption should also include the words, "without being embarrased or getting in over my head." The initiation of involvement is frequently such a psychologic hurdle that it is never negotiated. Everyone is different, but a slow approach is best.

Start at the County Society level; agree, when approached, to serve on a committee whose work and charge interest you. Let your natural interest and inclination lead you from there, to greater activity at the County Society level, leading to participation at the State Association level.

A good way to start your involvement at the State level is to represent MAG at the State Capitol during the Legislative Session. There are two ways to do this, one is as Doctor of the Day. This is a service that MAG provides for our State Legislators. We provide a physician every day during the Session. There is an Aid Station and an RN present. This is usually a light general practice, treating respiratory infections and advising Legislators and staff on health care problems. It provides the physician an opportunit to meet Legislators, have lunch with his or her own Legislator, and learn about the health-care issues before the General Assembly.

A second way to become more directly involved in the legislative process is to take part in the Physicians Involvement Program (PIP), which allows the physician to participate in Committee Hearings and other activities.

**What If I Don't Participate?**

The physicians of this State have shown over the years that they want to be involved in the shaping of health care delivery. We have demonstrated the dedication, expertise, and on-going commitment to make our voices heard on quality-of-care issues. We will remain our patients' advocate in our rapidlly evolving health care system.

If you remain silent and do not participate in your organization, we both lose. You lose in that you do not get to express your ideas and perspectives — perspectives that onl you have and can explain. The Association loses your effort, your expertise, your talents.

I urge each member to join your Association as we deal with the problems we face and will continue to face. It's *your* organization!

Jack F. Menéndez

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## QUOTES

*I am neither an angel nor a devil, but I have attributions from both heaven and hell, so I'm still just a man.*
DR. ALBERT SCHWEITZER

*Within us all there are wells of thought and dynamos of energy which are not suspected until emergencies arise.*
THOMAS J. WATSON

*There are people who say I have never really done anything wrong in my life; of course, they only say it behind my back.*
OSCAR WILDE

*A needle's eye is wide enough for two friends; the whole world is too narrow for two enemies.*
PERSIAN PROVERB

## PHYSICIANS, SCHEDULE SOME TIME FOR YOUR COUNTRY.

Many physicians would like to devote some time to their country in a local Army Reserve unit. We know that making a weekend commitment can be difficult for most physicians. So it is practical for the Army Reserve units to be flexible about time. It's worth discussing.

Incidentally, in addition to satisfying your own desire to serve your country, there are exceptional opportunities to do something totally different from a day-to-day routine. Opportunities to study new areas of medicine, meet new people in your specialty, and be a part of one of the world's most advanced medical teams.

Discuss the opportunities with our Army Medical Personnel Counselor.

## FOR SURGEONS LOOKING FOR A CHALLENGE.

Your challenge could be the Army Reserve unit near you. It's a unit that requires the services of surgeons.

You may wish to explore the challenge of teaching in a major medical center. You may wish to explore the special challenges of your specialty in triage. Certainly you'll be confronted by challenges very different from your daily routine.

You'll also have an opportunity to participate in a number of programs in which you'll be able to exchange views and information with other surgeons from all over the country.

The Army Reserve understands the time demands on a busy physician, so you can count on us to be totally flexible in making time for you to share your specialty with your country. We'll arrange your training program to work with your practice.

To find out about the benefits of serving with a nearby Army Reserve unit, we recommend you call our Army Medical Personnel Counselor.

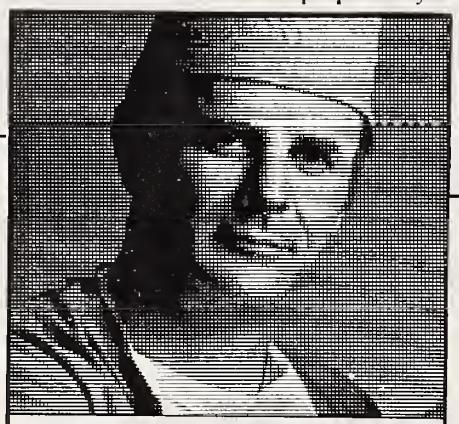
## PHYSICIANS, THERE ARE TWO KINDS OF FLEXIBILITY IN THE ARMY RESERVE WE THINK YOU'LL LIKE.

One, time. We know how tough it is for a busy physician to make weekend time commitments. So we offer flexible training programs that allow a physician to share some time with his or her country. We arrange a schedule to suit your requirements.

Two, the opportunity to explore other phases of medicine, to add a different kind of knowledge—the challenge of military health care. It's a flexibility which could prove to be both stimulating and rewarding, with the opportunity to participate in a variety of programs that can put you in contact with medical leaders from all over the country.

See how flexible we can be, call our Army Medical Personnel Counselor.

**ARMY RESERVE. BE ALL YOU CAN BE.**



## HERE'S ONE DOCTOR WHO WON'T PAY HIS MALPRACTICE PREMIUMS THIS YEAR.

The Army covers his premiums. Since he's an Army Physician, there are a lot of worries associated with private practice that he won't have to contend with. Like excessive paperwork, and the overhead costs incurred in running a private practice.

What he will get is a highly challenging, highly rewarding experience. The Army offers varied assignments, chances to specialize, or further your education, and to work with a team of dedicated health care professionals. Plus a generous benefits package.

If you're interested in practicing high quality health care with a minimum of administrative burdens, examine Army medicine. Talk to your local Army Medical Department Counselor for more information.

**ARMY MEDICINE. BE ALL YOU CAN BE.**

## MAJOR OPPORTUNITIES FOR HEALTH PROFESSIONALS.

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**Forest Park, GA 30050**
**Call collect: (404) 362-3359 or 3374**

# Ah, Sweet Summer!

THERE SEEMED TO BE unbounded limitations to the excitement ıd possibilities for pleasure, ·laxation, and distraction from the 'ork habit when we sat down early ı the year to plan the "summer ıcation." The boys had spent many ımmers in the past on the North arolina coast learning about boats ıd boating, becoming friends with ıe wind and learning to read it. It ıd seemed to us a part of raising ›ur boys and one girl that was a ırent's responsibility — the opening f the doors to the pleasures of ›ating. And so they went and so ıey learned not only about boat ıgines but mainly about sailboats ıd how to handle them. We had ied to do different things with them ı these "summer vacations" rough those many years but had ever quite gotten around to the easures of a sailing vacation. We ought and planned and dreamed; e read and sent for brochures and ıecked schedules. We finally ought we had it all down. It was to all the children and those with ives and an architect friend and his ife and son. We were to go to the ritish Virgin Islands.

There is a trick to it, you know — e accumulating of the things one eds on a vacation, with astute glect for those things one can do ithout. Instructions are carefully ovided in a little travel book ritten back in the early part of this ntury by a man called Jerome K. rome. He called It *Three Men In A oat,* to say nothing of the dog. It is travel book of sorts, describing the anning and the taking of a boat trip › the Thames River. It needs to be ad by anyone with any sort of carious interest in travel. There is a ace in this little volume where the ıthor describes an evening planning ssion between himself, as the ırrator, his friends George and arris and Montmorency (the dog) in hich they discuss the essentials hich one must consider in carrying ıt such a venture. The dialogue goes like this:

*"The first list we made out had to be discarded. It was clear that the upper reaches of the Thames would not allow of the navigation of a boat sufficiently large to take the things we had set down as indispensable; so we tore the list up, and looked at one another!*

*"George said: 'You know we are on the wrong track altogether. We must not think of the things we could do with, but only of the things that we can't do without.'*

*"George comes out really quite sensible at times. You'd be surprised. I call that downright wisdom, not merely as regards the present case, but with reference to our trip up the river of life generally. How many people, on that voyage, load up the boat till it is ever in danger of swamping with a store of foolish things which they think essential to the pleasure and comfort of the trip, but which are really only useless lumber.*

*"How they pile the poor little craft mast-high with fine clothes and big houses; with useless servants, and a host of swell friends that do not care two pence for them, and that they do not care three ha 'pence for; with expensive entertainments that nobody enjoys, with formalities and fashions, with pretence and ostentation, and with — oh, heaviest, maddest lumber of all! — the dread of what will my neighbour think, with luxuries that only cloy, with pleasures that bore, with empty show that, like the criminal's iron crown of yore, makes to bleed and swoon the aching head that wears it!*

*"It is lumber, man, all lumber! Throw it overboard. It makes the boat so heavy to pull, you nearly faint at the oars. It makes it so cumbersome and dangerous to manage, you never know a moment's freedom for anxiety and care, never gain a moment's rest for dreamy laziness — no time to watch the windy shadows skimming lightly o'er the shallows, or the glittering sunbeams flitting in and out among the ripples, or the great trees by the margin looking down at their own image, or the woods all green and golden, or the lilies white and yellow, or the sombre-waving rushes, or the sedges, or the orchids, or the blue forget-me-nots.*

*"Throw the lumber over, man! Let your boat of life be light, packed with only what you need — a homely home and simple pleasures, one or two friends, worth the name, someone to love and someone to love you, a cat, a dog, and a pipe or two, enough to eat and enough to wear, and a little more than enough to drink; for thrist is a dangerous thing."*

Looking back at it all following a safe arrival home, it seemed that we had done pretty well. We had, of course, taken along too much "lumber." But, the reason for our going in the first place had been gloriously achieved. We watched a sunset for its earliest beginnings to its majestic close. We learned that the dividends on monies spent for children's education and "upbringing" may not appear for years to come and had reveled in the confidence of children now grown to handle well themselves and their boats. We came again to realize that we could all get along quite nicely in close quarters. We and our architect friends were still good friends after a week of close communion on a sailboat, not an ordinary occurrence if one should think about it. And then, we had broken the sometimes monotony of daily work with something new and different and exciting. We were home again to find once more that the two best days of any "vacation" are "the day you leave home" and "the day you come home again."

Ah, sweet summer!

*Charles R. Underwood, M.D.*
*Editor*

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# *Would You Call This A Healthy Practice?*

The UAB Medical Center, through the Center for Health Professionals, is the first academic medical center in the nation to offer a chemical dependency treatment program designed *by* health professionals, *for* health professionals and their special needs.

The Center for Health Professionals is a results oriented therapeutic community designed exclusively for physicians, dentists and other health professionals impaired by the abuse of alcohol or other drugs. The UAB Medical Center, internationally known for its contributions to excellence in the clinical practice of medicine has committed the same effort to the Center for Health Professionals.

The priority at the Center is to provide the finest treatment possible. And to do so, it offers comprehensive inpatient care, outpatient follow-up services, family programs and retraining, all individualized to meet the needs of each patient. If necessary subspecialty care can be provided by the faculty of the UAB Medical Center.

For privacy and confidentiality, the Center is nestled in a secluded wooded setting, south of Birmingham, Alabama. Although our facility is new, our commitment to health care professionals is well established.

To receive more information in complete confidence, fill in and return the attached postage-paid reply card or call our toll-free telephone number today: 1-800-452-9860 and ask for the Center for Health Professionals.

**UAB** Medical Center
***Center for Health Professionals***

# Transmission of AIDS by Insects?

A RECENT REPORT on the recovery of human immunodeficiency virus (HIV)(AIDS virus) from bedbugs has rekindled the fear that AIDS could be spread by insects.[1] Laboratory-raised adult bedbugs *(Cimex lectularius)* and mosquitoes *(Aedes aegypti)* were fed blood with HIV-infected cells. One hour later, the insects were homogenized, centrifuged, and the resultant supernatant fluids were tested for 44 days, every 3-4 days for reverse transcriptase (RT), the enzyme found in HIV. On days 23 and 34, RT activity was found in the supernatant from the ground bedbugs; none was found from the mosquitoes. The authors noted that the 1-hour survival of HIV from *C. lectularis* suggested that bedbugs could mechanically transmit HIV.

There are two ways in which an insect could theoretically transmit a virus: cyclopropagatively and/or mechanically. If the HIV could successfully propagate within an insect, then spread might occur from body fluids of the insect. Malaria parasites, for example, develop within the mosquito; the parasites migrate to and concentrate in the mosquito's salivary glands. During feeding, saliva is injected to prevent clotting of blood, thus infecting the new host with the malaria parasite. In cyclopropagative transmission, the parasite has adapted to the insect vector. It has not been shown that HIV or any other retrovirus can multiply or complete its life cycle within an insect host; thus, the major concern has been mechanical transmission.

The spread of HIV infection among intravenous drug abusers from shared needles and to health-care workers via needlestick injuries suggests that mechanical transmission of virus could occur if an insect could function as a "flying needle." A critical factor to be considered is the volume of infected blood available for transfer. Although some insects regurgitate during a meal, they generally do not reinject the blood meal so painstakingly gathered from one host into another. Thus, transmission would have to come from whatever contamination exists on the biting parts. For example, the insect may finish a blood meal from an infected host and then have contaminated mouthparts when it goes to feed on its next victim. Alternatively, an insect could be interrupted while feeding on an infected host and dart off to a susceptible host to complete its meal. Both possibilities raise the issues of the interval between insect feedings, the duration of HIV survival on an insect's mouthparts, and the quantity of blood actually on the mouthparts.

Insects that induce painless bites (mosquitoes, bedbugs, ticks, lice, fleas) are more likely to complete a blood meal than insects that induce a painful bite (tabanids, stable flies). Thus, they represent a lesser threat of mechanical transmission because they do not need to seek an alternate host to complete an interrupted blood meal, and also because they have smaller mouthparts to become contaminated. The mouthparts of insects that feed on blood from extravascular sites have a larger surface area for blood contamination than do insects such as mosquitoes that obtain blood from the capillaries. Thus, these types of insects are more likely to be involved in mechanical transmission.

Equine infectious anemia (EIA), like HIV, is a retrovirus. EIA has not been shown to multiply in insect cells or to be maintained within free-living insect populations.[2] Mechanical transmission of EIA virus by deer flies and stable flies has been shown in laboratory conditions.[3] In these experiments, the flies were immediately transferred to a susceptible pony after interrupted feeding on an infected one. These experiments suggest that mechanical viral transmission by large biting flies could occur under certain conditions.

As of December 31, 1985, of 305 health care workers (HCWs) with sticks from blood-contaminated needles from AIDS patients, two showed serologic evidence of infection following the injury (risk <1%).[4] There have been no infections demonstrated among HCWs with non-parenteral exposures to blood or body fluids of AIDS patients. These data suggest that the risk of transmission from an insect fluid contamination on the surface of human skin would be essentially zero. Given the smaller volume of blood an insect might be able to inoculate through the skin of a human compared to a needle, the risk from an insect bite would seem to be lower than for the HCWs from needlesticks.

The volume of blood necessary to transmit hepatitis B virus appears to be much lower than HIV, as evidenced by the greater risk of hepatitis B infection from hepatitis B-contaminated needlesticks (20% vs <1%).[5] In 1983, a homosexual man with acute hepatitis B was bronchoscoped. The bronchoscopist sustained a needlestick and 15 weeks later developed signs of hepatitis B. The homosexual patient died of AIDS 8 months later. The bronchoscopist had no HIV antibodies,[6] thus illustrating the viruses' relative infectiousness.

Hepatitis B antigen has been demonstrated in wild African mosquitoes.[7] Yet, there has been no convincing evidence of transmission of hepatitis B by mosquitoes. Berquist et al allowed *Culex* and *Aedes* mosquitoes to feed on hepatitis B-infected chimpanzees.[8] The feeding was interrupted and the mosquitoes were allowed to complete feeding on susceptible chimps. Although homogenates of mosquitoes showed

the presence of hepatitis B surface antigen, the exposed chimps remained uninfected, suggesting no risk of mosquito-related mechanical transmission of a virus more infectious than HIV.

The distribution of cases of AIDS also argues against insect transmission. Obviously, mosquitoes and other insects bite teenagers, females, members of groups not at risk of AIDS, and persons sharing the same households as persons with AIDS. Yet, there is a paucity of cases of AIDS among teenagers, and the number of males with AIDS greatly outnumbers the females with AIDS. The proportion of cases with no identifiable risk factors remains small and has not shown substantial change over time. Finally, there has been no evidence of spread of infection within the household of AIDS patients.[9, 10]

The mere isolation of HIV from an insect does not prove transmission. If an earthworm were fed on blood-soaked dirt and the worm was ground up and virus recovered, would this imply that worms could spread AIDS? Reasons for the decline in arthropod-borne disease in the U. S. include better housing, screening, water management, vector control programs, and a low prevalence of human infections that could successfully propagate in insects. While it may be possible for HIV infection to be transmitted by certain insects (e.g., large biting flies) under certain conditions, the information to date gives no documentation for insect transmission as a major route of spread and considerable evidence to the contrary. Insect-related mechanical transmission of HIV remains a theoretical possibility; however, the efficiency of such a mechanism of spread would be extraordinarily low.

*References available upon request.*

(Reprinted from *Georgia Epidemiology Report,* Vol. 3, No. 4, 1987.)

# *Tickborne Diseases in Georgia, 1986*

ROCKY MOUNTAIN SPOTTED FEVER (RMSF) is transmitted primarily by the American dog tick, which must usually be attached for >6 hours in order to transmit RMSF. The incubation period ranges from 3-12 days. Symptoms include headache, fever, chills, and myalgias. About day 3 of illness, a rash appears on the wrist and ankles and then spreads inward.

During 1986, 40 cases of RMSF were reported in Georgia. *Two of these cases resulted in death* (case fatality rate = 5%); both were white females <10 years of age (residence = Cherokee County, Elbert County). In both cases there was a delay of >3 days before seeking medical care.

The following counties reported more than one case: Baldwin (3), Clarke (3), DeKalb (3), Bartow (2), Cherokee (2), Cobb (2), Gordon (2), Gwinnett (2), and Rockdale (2). Thirty-two cases (80%) had onset during May, June, or July. The age range was 3-64 years (median age = 26 years); 28 (70%) were male; 40 (100%) were white; and 25 (62.5%) were hospitalized. There was a history of tick bite or exposure to a tick infested area in 35 (87.5%) cases, 26 (65%) actually had a tick attached within 14 days prior to onset, and 29 (72.5%) had no travel outside their home county. Fever and headache were present in 22 (55%) cases and 31 (77.5%) developed a rash. Tetracycline was used to treat 32 (80%) cases, while 8 (20%) were treated with chloramphenicol or other drugs. Overall, 27 (67.5%) cases were laboratory-confirmed.

*LYME DISEASE* is caused by a spirochete transmitted by infected *Ixodes dammini* ticks. Symptoms include a red, ring-like lesion at the bite site, headache, fever, chills, nausea, vomiting, diarrhea, stiff neck, myalgias, and swollen lymph glands. Untreated Lyme disease can cause serious joint or neurological problems. Although seen nationwide, no cases of Lyme disease have been reported in Georgia.

*EHRLICHIOSIS,* caused by the rickettsial organism *Ehrlichia canis,* is a recognized tick-borne pathogen of dogs, but illness in humans had not previously been documented. Within the past year, four Georgians had serologic evidence of recent infection with *E. canis* or a closely related species. All patients reported being bitten by ticks within 3 weeks of the onset of symptoms including malaise, low back pain, fever, rigors, headache, nausea or vomiting, and anorexia. Laboratory abnormalities included anemia, leukopenia, lymphopenia, thrombocytopenia, and abnormal liver function tests.

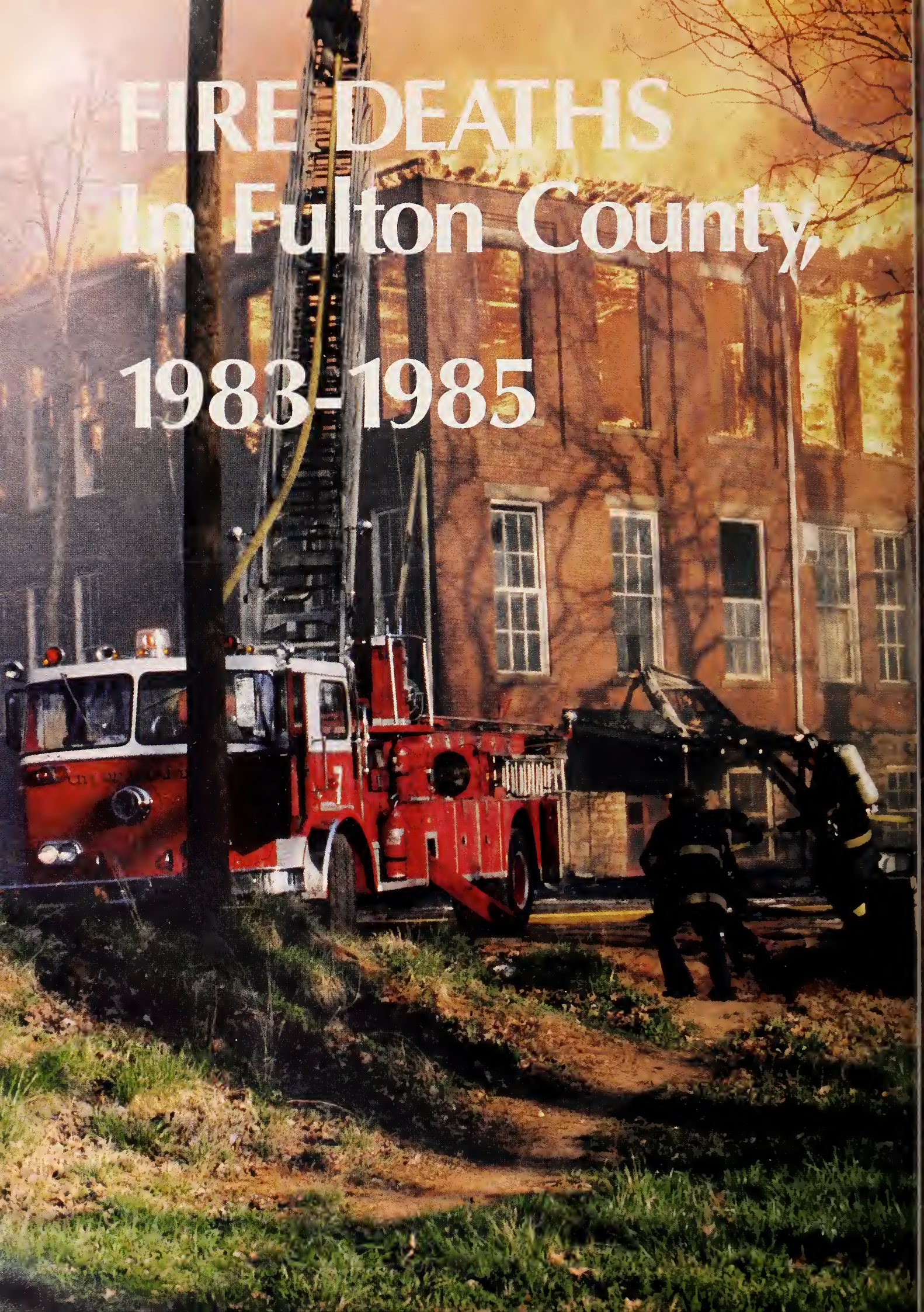
*TULAREMIA* is caused by the gram-negative organism, *Francisella tularensis.* The illness is usually characterized by high fever, severe influenza-like constitutional symptoms of chills, myalgia, and headache. Commonly, a painful, slow-healing, maculopapular lesion appears at the entry site. The incubation period ranges from 2-10 days.

During 1986, four cases of tularemia were reported in Georgia. The age range was 39-63 years; three (75%) were female. Months of onset of illness were January, February, April, and November. Counties of residence were Hall, Henry, Newton, and Walton. One case acquired infection from an injury while dressing wild rabbits. Tick exposures are a possible source for the other cases.

*Editorial Note:* During visits to tick-infested areas, twice a day body inspections help to remove ticks before transmission occurs. Using sharp pointed tweezers, grasp the tick as near the skin as possible. Gentle, steady tugging pressure allows the tick to release the attaching hooklets

*(Continued on p. 530)*

# FIRE DEATHS In Fulton County, 1983-1985



Ann Early, M.D., Randy Hanzlick, M.D.

## Introduction

FIRES AND CONFLAGRATIONS reportedly constitute the fourth leading cause of accidental death in the United States.[1] Most (>80%) are residential fires with one or two victims.[2] The death rate due to fires has ranged nationwide from 2.4 to 2.9 deaths per 100,000 population from 1976 to 1980.[2,3] Surveys show an increased risk for blacks, children, and the elderly.[1-3] The present study was initiated to determine how fire deaths in Fulton County (and Atlanta) compare to national trends.

## Methods

All fire deaths which occurred in Fulton County between November 1, 1983, and October 31, 1985, were reviewed. A total of 42 cases were identified by a search for causes of death which included smoke inhalation or thermal burns. Annual death rates due to fires were calculated using population data extracted from 1983 Fulton County Vital Statistics. Demographic and circumstantial variables were reviewed.

## Results

The majority of the 42 fire deaths were accidental (92.8%). One death was homicidal, and one was suicidal. The homicide resulted from a police confrontation in which a tear gas cannister exploded and caused a house fire, while the suicide resulted from self-immolation in a vehicle. Several fires were actually set to conceal homicides, but those deaths were excluded from this study since the fires did not cause death.

A total of 33 deaths (79%) were due to 25 residential fires in 16 houses and 9 apartments. Four additional deaths occurred in one fire in a vacant business building, another in a vacant house, and one death was due to a clothing fire with no structural damage to the residence. One of three vehicular fires resulted from a two-car accident in which the victim's car caught fire, one was due to an intoxicated man falling asleep in his car while smoking, and the third was suicidal. Thus, 30 fires accounted for the 42 deaths; eight fires (27%) killed multiple people, and the greatest number of persons killed by a single fire was four.

Smoke inhalation was the most common cause of death (61%), followed by smoke inhalation and thermal burns combined (20%), and thermal burns only (17%).

The average annual fire death rate was 3.5/100,000 population. Blacks and males were at increased risk, with fire death rates for blacks being 2.25 times that of whites, and male rates which were 1.7 times that for females (Table 1). The increased risk for males was due to a noticeably high risk for black males; white male rates were lower than white female rates (Table 2).

The fire death rate was markedly increased in the very young and elderly, with a rate of 7.0 for persons 4 years old or less, and 13.6 for persons 75 years of age or older (Table 3). In contrast, the rate for persons aged 10 to 65 years was 2.6

The seasonal pattern of fire deaths was also examined. A total of 40.5% occurred during January, February, or March, while 78.6% occurred during the 6-month period of October through March (Table 4).

Of the 25 residential fires, 40% (10) were known to be caused by appliances or electricity. Four fires were due to gas heaters which caused adjacent material to catch fire. Others were due to a faulty electric heater (1), an electrical short in a television (1), a faulty furnace (1), an iron which was left on a flammable surface (1), an electric heating pad on a flammable surface (1), and a faulty electrical outlet (1). Twelve percent (3) were initially thought to be due to careless smoking. Sixteen percent (4) of the residential fires were due to various causes which included a candle used for light in a home with no electricity, a cigarette lighter mishap, and two food fires in kitchens. The remaining 32% of residential fires had no cause

From the Office of the Medical Examiner, Fulton County; Department of Pathology and Laboratory Medicine, Emory University School of Medicine, Atlanta. Send reprint requests to Dr. Hanzlick, 50 Coca Cola Place, Atlanta, GA 30303.

TABLE 1 — Fire Death Rates in Fulton County, by Race and Sex

| *Category* | *N* | *Fire Death Rate* | *B/W Ratio* | *M/F Ratio* |
|---|---|---|---|---|
| Black | 30 | 4.5 | | |
| White | 11 | 2.0 | | |
| Other | 1 | 8.4 | | |
| | | | 2.25 | |
| Male | 25 | 4.4 | | |
| Female | 17 | 2.6 | | |
| | | | | 1.7 |

TABLE 2 — Fire Death Rates per 100,000. Fulton County, Georgia, 1983-1985

| | |
|---|---|
| Males | 4.4 |
| Females | 2.6 |
| Whites | 2.0 |
| Blacks | 4.5 |
| White males | 1.8 |
| White females | 2.1 |
| Black males | 6.1 |
| Black Females | 3.0 |
| Overall | 3.5 |

Table 3 — Relationship of Fire Death Rates and Age, Fulton County, Georgia

| | *FIRE DEATH RATE* | | |
|---|---|---|---|
| *Age Range* | *Fulton County (1983-85)* | *Georgia (1979-81)* | *U.S. Metropolitan (1976-77)* |
| All Ages | 3.5 | 4.5 | 2.9 |
| 0 to 4 (6) | 7.0 | | 5.3 |
| 5 to 9 (1) | 1.1 | | 2.0 |
| 10 to 14 (0) | — | | 1.1 |
| 15 to 19 (2) | 2.0 | | 1.2 |
| 20 to 24 (0) | — | | 1.7 |
| 25 to 34 (3) | 1.3 | | 1.7 |
| 35 to 44 (6) | 3.8 | | 2.0 |
| 45 to 54 (9) | 7.8 | | 2.9 |
| 55 to 64 (4) | 4.1 | | 4.1 |
| 65 to 74 (4) | 5.2 | | 5.8 |
| 75 & older (7) | 13.6 | | 11.6 |

TABLE 4 — Fire Deaths by Month. Fulton County, Georgia, 1983-1985

| | |
|---|---|
| July | 1 |
| August | 0 |
| September | 3 |
| October | 8 |
| November | 3 |
| December | 5 |
| January | 7 |
| February | 5 |
| March | 5 |
| April | 2 |
| May | 3 |
| June | 0 |

specified initially and were assumed to be due to careless smoking. Only one accidental fire was known to have been started by a child less than 10 years of age.

Of the 42 fire victims, 35 were older than 10 years of age, and 27 had blood alcohol levels performed. Seventeen (63% of those tested) had a blood alcohol level of 0.1mg% or greater, while 74% had detectable levels of alcohol in their blood (Table 5). Of those with blood alcohol levels of 0.1mg% or greater, 82.3% were male (Table 6).

## Discussion

As with national trends, the majority of fire deaths were accidental and due to residential fires. Also typically, most deaths were due to smoke inhalation rather than thermal burns.[2,4,5]

The CDC reports a fire death rate of 4.46 for Georgia between 1979 and 1981,[2] comparable to the rate of 3.5 observed for Fulton County. The South reportedly has the highest fire death rates, consistent with the observed rate of 3.5 in Fulton County which is higher than the national rate of 2.4 to 2.9.[2,3]

A total of 83% of the fire deaths occurred in the City of Atlanta which accounts for about two-thirds of the County's population, is about 70% black, and contains the residential areas with the highest population densities. Countywide, the black population is about 51%. Our finding of increased risk in blacks is consistent with reported trends.[1-3] Mierley and Baker[4] note that fire death rates were highest in census tracts with low property rental values. The geographic distribution of lethal fires in the City of Atlanta showed concentration in the lower income and more densely populated areas of the City, implicating socioeconomic factors as an explanation for increased risk among blacks.

The increased fire death rate for males was accounted for by black males (Table 2). In fact, white males were at lowest risk of the four major race/sex groups. The explanation for such a finding is not clear, but is not related to

**TABLE 5 — Blood Alcohol Levels in 27 Fire-Related Fatalities Tested for Blood Alcohol**

| *Blood Ethanol (mg%)* | *N* | *% of Total Tested (27)* |
|---|---|---|
| 100 mg% or greater | 17 | 63.0% |
| 50 mg% or greater | 18 | 66.7% |
| Any detectable level | 20 | 74.1% |

**TABLE 6 — Alcohol Involvement for Female and Male Fire Victims Who Had Blood Alcohol Tests Performed**

| *Category* | *N* | *% of Total Tested* |
|---|---|---|
| Adult female fire victims tested | 11 | |
| . . . ethanol 100 mg% or more | 3 | 27.3% |
| Adult male fire victims tested | 16 | |
| . . . ethanol 100 mg% or more | 14 | 87.5% |

fires which killed multiple persons. Interestingly, five of six white female victims were in high risk age groups (childhood or elderly) while the five white male victims ranged in age from 16 to 39 years, a relatively low risk age group.

Death rates were significantly higher for children and the elderly, again reflecting national trends (Table 3). One explanation is that persons of such ages are not generally as capable of saving themselves as older children and younger adults. Also, because of health problems in the elderly and increased respiratory exchange in children, lethal carbon monoxide levels in those age groups are lower than in other age groups.

There was clearly an increase in fire deaths during colder months (Table 4). Such a finding is thought to be due to the use of additional and perhaps improper or unsafe heating or lighting devices, which may also relate to socioeconomic conditions. Such hazards were exemplified by several winter fires in our series which were caused by gas or electric heaters, a fire which killed four transients who were sheltering themselves in a vacant building, and another fire due to a candle used for light in a house with no electricity. Two multi-victim fires were largely responsible for the prominent October peak in our data (Table 4), and all but one of the eight multi-victim fires occurred during colder months. Such findings would be expected since people tend to spend more time inside during colder times of the year.

The finding of blood alcohol in 74.1% of all victims tested and 87.5% of all male victims tested clearly indicates that alcohol use or abuse is intimately related to many fire deaths (Table 5). Mierly and Baker[4] and Gormsen et al.[5] have also documented the association of fire deaths and alcohol use.

An attempt was made to obtain information from the Fire Department concerning the availability of adequate escape routes, fire extinguishers, and the use or non-use of smoke detectors at the fire scenes. The availability of escape routes and fire extinguishers are reportedly not evaluated on a routine basis during the investigation of fire deaths. Recently, an evaluation of smoke detector status has become part of routine investigation, but the number of cases for which data were available was so small that meaningful analysis was precluded. In view of the high incidence of alcohol involvement in fire deaths, often at levels which are intoxicating or sleep promoting, one would question how effective such safety features would be if they were present. Such a pessimistic outlook should not preclude the installation of such devices, however, and it would seem appropriate that the use or non-use of safety features be evaluated by the medical examiner and/or fire department.

In summary, fire deaths in Fulton County follow most national trends. Most fires were accidental and residential. A fire death rate of 3.5/100,000 population was observed, with risk factors which included race (blacks), sex (males), age (children and the elderly), season (colder months), and alcohol abuse. Socioeconomic status may play a pivotal role in determining risk, and investigative agencies must be thorough in order to design effective prevention strategies.

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# ANABOLIC STEROIDS

**J. Nicholas Gordon, M.D.**
**and MAG Medical Aspects of Sports Committee**

ANABOLIC STEROIDS are synthetic chemical derivatives of the male hormone testosterone. One effect of testosterone is anabolic, as evidenced by the increased muscularity of a male as compared to a female. Other effects of testosterone include the development of secondary male sexual characteristics such as deepening of voice and stimulating the growth of facial hair. Testosterone is also believed to be responsible for the more aggressive behavior of males.

Biochemical effects of testosterone include retention of salt and water, which may produce high blood pressure; increase in blood cholesterol and changes in the blood lipids; and retention of calcium. Testosterone also is known to prematurely close the epiphyses in growing individuals, hence limiting their growth. Anabolic steroids retain the anabolic effects of testosterone, but the biochemical and epiphyseal closure effects are lessened.

The use of anabolic steroids by athletes began about 30 years ago, primarily by weight lifters and men in field events. These were used to increase weight and strength. Since that time, usage has spread to athletes in all sports.

## Why Athletes Use These Drugs

Many believe that their competitors are taking these drugs, and hence they must also use them to stay competitive. Obtaining these drugs is not difficult. They are available through "order houses" and "dealers" who frequently approach athletes. Athletes may take up to 100-200 times the normal recommended doses. Such large doses increase the risk of adverse effects.

## Effectiveness of Anabolic Steroids

Controlled double blind studies have proven difficult to conduct. In many cases, participants can determine when they are using the anabolic steroid as a result of the physical and physiologic effects they are experiencing.

The campaign against anabolic steroids would be strengthened immeasurably if one could declare the drugs completely ineffective, in addition to being harmful. However, as noted in the Position Stand of the American College of Sports Medicine, anabolic steroids "can often increase strength gains beyond those seen with training and diet alone." Some muscle enlargement has been attributed to water retention. Yet, many researchers feel that the psychologic knowledge of steroid use is an important factor, and the athletes work more diligently as a result of greater drive and energy.

Anabolic steroid use is not effective in enhancing strength unless combined with a resistive exercise program. Also, it is only the world-class athletes who benefit from the small increases in strength obtained.

Complications of steroid use include early epiphyseal closure, testicular atrophy, sterility, acne, gynecomastia, liver disorders (hepatitis and tumors), baldness, retention of salt and water, and changes in blood cholesterol. Furthermore, in females, deepening of the voice, growth of facial hair, and enlargement of the clitoris can occur and may be irreversible.

## Testing

Incentive for using these drugs may diminish when all athletes can be assured that no competitor is benefiting from their use. Frequent testing of all participants is now being done by many universities and the Olympic Committee. Although the tests are expensive and difficult to perform, they are quite sensitive, and anabolic steroids can be detected months after their use is discontinued. Sanctions against the use of steroids are quite severe.

As testing becomes increasingly prevalent, it is hoped that athletes can once again participate in a drug-free atmosphere, where natural ability enhanced by proper training and conditioning techniques and not chemical manipulation determines the winner.

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## *Organized Medicine's Challenges Today:*

# "THE GOOD, THE BAD, AND THE UGLY"

**James H. Sammons, M.D.**

I'M PLEASED that you invited me to be the keynote speaker for this important conference. I have been asked to talk about the challenges organized medicine faces today. That assignment reminds me of a Clint Eastwood movie, because I see some good, some bad, and *some* things that are just plain ugly. And since this conference is focusing on tort reform and malpractice litigation, as well as quality care, let me start with those challenges that are the ugliest ones we face.

There are four primary issues: professional liability, the "bundling" of physician Medicare reimbursement, the companion problem of mandatory assignment, and the current Medicare proposals. In a recent survey we conducted, physicians indicated that professional liability was the main problem facing medicine in the U.S. today. In 1983, liability was near the bottom of their list of concerns. The recent protests in Florida that forced 17 Dade County hospitals to place restrictions on their emergency room service highlight a problem that all of us are much too familiar with. While about half of the states passed tort reform legislation last year, it's still not enough. Physicians are growing more and more dissatisfied with what their state legislatures are doing, or not doing, to reform tort laws. Nearly half of all the physicians we interviewed said they were not at all satisfied with current efforts to change the laws that govern professional liability claims. Clearly, we need to do something to bring skyrocketing liability insurance premiums back to earth. Unless we do something quickly, I think we'll see continuing premium increases, and no doubt substantial ones at that. I have to believe what a St. Paul official said to me recently, that they will have 25 to 35 percent increases during the next 5 years, compounded annually. That's a terrible prospect. But unless something happens in the state legislatures to curb the current trend, I have to believe him.

I understand the Georgia Insurance Department and St. Paul have reached an agreement that will eliminate the "surcharge plan" St. Paul started last April. I applaud you on that victory. But I have to warn you, too, there's still much left to do. This crisis has forced a lot of physicians to rethink the way they practice. Nearly one out of five OB-GYNs in the country has stopped delivering babies and in Georgia, that figure is one out of three. And the problem is affecting other physicians, as well. So, as I see it, professional liability will continue to be a challenge in the future. As

Dr. Sammons is Executive Vice President, American Medical Association. This speech was given at MAG's Leadership Conference last January in Atlanta.

grim a prediction as that is, it's one we'll be forced to live with until we can change the tort system in this country.

Another of the ugly challenges facing medicine is the proposal by the federal Office of Management and Budget to "bundle" some physician Medicare reimbursements into DRG payments. In my opinion, this poses the worst threat to medicine and patient care since the national health insurance proposals of 1963. And let me tell you this, the federal government has a fight on its hands over this one! The government says that they have adopted a "compromise" position. And that position calls for *only* the inclusion of radiologists, anesthesiologists, and pathologists in the proposed DRG package. But I don't call that a compromise at all, it's a sell-out. And the AMA is not going along with it! I don't think there's anyone out there gullible enough to believe that the government would stop at radiologists, anesthesiologists, and pathologists.

***"Another of the ugly challenges facing medicine is the proposal by the federal Office of Management and Budget to 'bundle' some physician Medicare reimbursements into DRG payment."***

The government got their foot in the DRG door with hospitals. This is just an attempt to get the door open wide enough to force their knee through. Before you know it, they'll be trying to slip in an elbow or a shoulder. And before long, they'll have the door open all the way, and physicians that treat Medicare patients will have their reimbursement schedules all worked out for them, in Washington!

This DRG proposal is close kin to two other proposals that have come out of Washington: mandatory assignment and the Medicare legislation passed last year that forces physicians to choose to participate or not without giving them enough information to make an informed decision. All three of these actions show a vacuum of understanding by government officials on the medical issues. And the ones that are really hurt here are the people Medicare and these government officials are supposed to be protecting: the elderly patient. By their actions, government decision-makers are actually penalizing patients by depriving them of their right to go to the doctor they want, the doctor they like, the doctor who knows and understands their problems. And they're driving a lot of physicians out of the Medicare program altogether.

That's why the AMA, the Texas Medical Association, a county medical society, *and* individual patients and physicians gave the federal Department of Health and Human Services a Christmas Eve present. That day we filed a suit in Lubbock, Texas, against HHS that sought permanent relief and a preliminary injunction against enforcement of provisions of the Omnibus Budget Reconciliation Act of 1986. Now all that's lawyer talk that means we wanted the federal court to prevent the implementation of Medicare provisions that would require physicians to establish mandatory fee schedules. The court granted a temporary restraining order, but last week our request for a preliminary injunction was denied. I'm naturally disturbed by the court's action. And I'm bothered even more by the fact that patients who elect to keep longstanding relationships with their physicians will be penalized as the law goes into effect. And physicians will be harmed, too, because the government has failed to provide the information physicians need to make an informed decision and to comply with these new complex fee controls. But we're not through yet. The AMA intends to press forward with our claims that the new Medicare law violates constitutional guarantees, and we hope for an early trial date. That covers some of the real ugly prospects we face.

***"The Alliance of State Physician Networks made a very persuasive presentation to our Board of Trustees on the need for a uniform physician response to the CHAMPUS Reform Initiative."***

Next, I want to mention some that, while not as grim as the ones I've already discussed, are bad for the profession. One of the issues that has generated a lot of discussion is DoD's new CHAMPUS Program. While I recognize that many state medical associations, including the Medical Association of Georgia, have deep interests in the CHAMPUS Reform Initiative, there are good reasons for the AMA not to get involved. John Watson's group, the Alliance of State Physician Networks (ASPN), made a very persuasive presentation to our Board of Trustees on the need for a uniform physician response. But while we share ASPN's concerns for physician autonomy, freedom of choice and DoD's overall goal of improving CHAMPUS beneficiaries' access to quality care, there are some aspects of the DoD initiative that trouble us. For one, we were concerned about how the proposed geographic capitation system would affect the quality of care. And there seems to be some question about how the DoD will change the CHAMPUS Program in response to recommendations and suggestions from con-

cerned groups, including the AMA. Since AMA members come from a broad spectrum of practice arrangements, we believe that it is inappropriate for the AMA to focus any special IPA "networking" activities toward the CHAMPUS Program. It's the AMA's responsibility to provide the same high level of support and assistance to all physicians or groups of physicians seeking innovative ways to respond to the competitive environment. To do otherwise would be more divisive than helpful to organized medicine, and to the physicians we represent.

But besides the impact of the CHAMPUS Program changes, there are other trends in the world of medicine that bode far more serious consequences for the future of the profession. And they're happening right where new doctors are created in medical education. One problem I see is the declining number of medical school applicants. The applicant pool is down by one-third since 1975. I'm not primarily bothered by the declining number of applicants, indeed, with warnings of a physician oversupply, we have to expect that some prospective applicants would be disenchanted with job prospects. My main concern is that we continue to draw the high quality of talented, creative people that we've attracted in the past.

***"... the situation in graduate medical education isn't helping our efforts to attract the top students."***

But with the bad press we've gotten on the liability problem, with the escalating costs of medical education and the enormous time commitment to education and training, many of our brightest young people are going to be unwilling to mortgage their futures for a career in medicine. A career, I might add, that may not appear all that promising to them. And so they'll turn to business, banking, computer science, engineering or law. We can't afford to let that happen. We need to encourage our top high school and college students to consider the rewards of medical practice not just the drawbacks they may now perceive.

But I'll have to admit that the situation in graduate medical education isn't helping our efforts to attract the top students. There's a major challenge facing us here in the next five or six years. And the biggest problem is funding, where it's going to come from, its impact on the number of available residencies, and the question of how American-born foreign-trained medical students are going to be placed in the ever-constricting residency arena. Because of the government's reduction of residency stipends and support for indigent patients, we're facing the prospect of severe restrictions in residency programs. The government has a two-fold purpose in this, first, to cut federal spending, and second, to shift physicians to primary care disciplines. Since, according to statistics, the growth of primary care physicians between 1979 and 1984 was at a slower rate (14 percent) than the surgical specialties (17 percent), the government wanted to add some incentive for physicians to go into primary care. And the way they did that was by limiting residency stipends to first board eligibility plus one year to a maximum of five years. So physicians who need funding for graduate medical education beyond the five-year cap will have to secure it themselves. And federal budgets continue to slice away at the indirect funding to teaching hospitals. We all know, as the federal government goes, so go the state governments and insurance companies, so we can expect continued overall cuts in graduate medical education. One result is that residency program choices for physicians will become more and more limited.

And to describe a worse case scenario, if the situation continued on its current course, we would see a time when there would be virtually no choice in residency programs. In fact, physicians would be lucky if they got a slot at all. But we'll never see that. Organized medicine won't let the situation get to that point. Nevertheless, the situation in graduate medical education is clearly bad.

By now you're probably wondering if there's anything good in medicine to go along with the heavy dose of bad and ugly that I've given you. And you can be sure that there are some good things happening, lots of them. In our efforts to secure tort reform, cooperation among state and local medical societies and the AMA has never been better. And we have been working closely with the specialty societies to put together a unified campaign that will lead to meaningful tort reforms. Your own Physician Involvement Program is a model of what we ought to be doing as physicians to get our message across to state legislators.

***"In our efforts to secure tort reform, cooperation among state and local medical societies and the AMA has never been better."***

In addition, physicians will have an opportunity to become stronger health care advocates in the future. The AMA is involved in two initiatives that, I think, will be monumental in terms of improving health care delivery to the citizens of this country.The first one is the Health Policy Agenda for the American People. This project will lay the

groundwork for health care trends leading well into the next century. And the wonder of it all is that it's the product of deliberations between more than 100 organizations, such as HHS, DoD, and the Veterans Administration, the Business Round Table, the National Medical Association, the American Association of Retired Persons, representatives from labor, nursing, hospitals, and many, many more. There wasn't 100 percent consensus among the representatives on what we needed to do. But that wasn't the purpose of the project. The goal was to sit down and talk about the problems and try to find workable solutions. The project's report will be out shortly. And once it's issued there will be a lot more to talk about.

The second initiative focuses on the health care needs of adolescents, the almost forgotten segment of our population. Here, too, there's a lot to do. The statistics are shocking: 5,000 adolescent suicides a year, one every 90 minutes; 8,000 teenagers killed and 40,000 injured each year in traffic accidents caused by drugs or alcohol; one million teenage girls become pregnant every year; 900,000 adolescents, boys and girls, caught up in the labyrinth of prostitution. These are just a few of the numbers. I could go on and on.

***"The AMA is involved in two initiatives that, I think, will be monumental in terms of improving health care delivery to the citizens of this country."***

Physicians are going to have a crucial role in formulating responses to the health care needs these projects identify. And that's the way it should be, because if there's one thing we've learned in the recent years, it's that we have to be innovative and adaptable in supplying health care. Alternative health care delivery systems have taught us that. So today, patients have a real smorgasbord of systems to choose from. That's not all bad either. I don't think there is any one system that's ideal for physicians or patients, so physicians have to be flexible and careful, too. More than one of these plans has gone under because of poor planning and underfunding. But I know I don't have to worry about you and your statewide IPA, Georgia Health Network. I'm confident enough in your leadership to know that they've given this project serious consideration and analysis.

So with that I'll conclude my forecast on the challenges to medicine. It's not all roses out there. Some things look pretty bad; others, just mud ugly. But overall, I'm optimistic about the future. I think we'll make some important progress on many of the challenges we're facing. And I think we're going to have a chance to make significant contributions in planning for the health care needs of the future. But we all need to stand together. We need your help, and I think we can help you, too. Because, like it or not, we're all in this together. And that isn't going to change.


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# The Joint Commission's "Agenda for Change"

Dennis S. O'Leary, M.D.

> **"The Agenda for Change will put the Joint Commission in a far more supportive and facilitative mode in helping health care organizations meet the responsibility for quality of care that the public, not the Joint Commission, has imposed on them."**

### Introduction

The Joint Commission's Agenda for Change is comprised of three inter-related initiatives that together are intended to launch a new era for quality assurance in health care. These three initiatives include:

- An accreditation and surveys initiative to enhance the Joint Commission's ability to evaluate quality of care and promote improvement in the delivery of health care services.
- A communication initiative to maintain and enhance Joint Commission relationships with provider organizations and health care professionals while fostering broader relationships with the government, business, labor, insurance, and consumer communities.
- An education initiative to expand and enhance Joint Commission education and consultation services.

The purpose of this paper is to describe the first initiative in more detail, since it lies at the heart of the Joint Commission's commitment to promoting the highest possible quality in patient care. The Joint Commission shares with health care providers a mutual investment in continually improving quality of care. The wide range of experience and expertise available within the health professions will be a major asset in undertaking this challenging initiative.

Dr. O'Leary is President of the Joint Commission on Accreditation of Hospitals. He spoke at MAG's Leadership Conference last January in Atlanta. This is a background paper describing new initiatives of the JCAH.

### The Changing Health Care Environment

Since 1951 the Joint Commission has worked to improve quality of care in organized health care settings. Building on the successes of the past 35 years, the Joint Commission's Agenda for Change is an evolutionary development in carrying out this mission. Over the past several years the Joint Commission has:

- established more collaborative relationships with accredited institutions,
- individualized the survey process and improved the accuracy and consistency of accreditation surveys,
- increased the consultative and educational emphasis of surveys while decreasing "inspection" activities, and
- introduced standards that are more descriptive of desired "ends" and less prescriptive of required "means."

These advances, however, are not sufficient in the current environ-

ment. Because of resource limitations and altered payment incentives, identifying and addressing potential quality of care problems is now a major public policy issue. Whereas previously there was an implicit assumption of high quality — based in large part upon the public trust in physicians and health care organizations — the public through government, business, insurors, consumers, and other interest groups is seeking information concerning clinical performance and other dimensions of quality care. Health professionals share this interest. How good is the care being provided? Is it changing over time? What response is expected when care is found to be substandard?

The issue is further sharpened by the current major restructuring of the health care system. Service diversification, managed care, risk sharing, vertical and horizontal integration, and corporatization of care all add new variables to an already complex equation. The net result potentially creates a diffusion of responsibility for quality in an environment significantly influenced by cost considerations.

### Challenge to the Joint Commission: Evaluating "Quality of Care"

For the Joint Commission to answer the difficult questions which have been posed, it is essential to move beyond the current primary focus on evaluating a hospital's or health care organization's *capability* of delivering quality care. At present, accreditation attests to an institution's compliance with accepted standards of structure and process and answers the basic question: "*Can* this organization provide quality health care?"

Recent advances in health care research methods and database development now permit more precision in monitoring clinical performance and improving the quality thereof. With the completion of the project described in this paper and the shift from sole reliance on the analysis of administrative performance to the monitoring and evaluation of clinical performance, the Joint Commission should be able to help institutions better answer the question, "*Does* this organization provide quality health care?"

**"Health care quality is analyzed by a review of the structures, processes, and outcomes of diagnosis and treatment as well as their interrelationships."**

Health care quality is analyzed by a review of the structures, processes, and outcomes of diagnosis and treatment as well as their interrelationships. Clinical excellence, in turn, relies upon and is supported by quality in the organizational environment — the managerial context within which patient care is delivered. Both clinical and organizational excellence are the essential components of quality, and the Joint Commission is convinced that it is appropriate and timely to undertake more direct assessment of each. This effort will result in better definition and measurement of clinical and organization performance and, where possible, will determine the relationship between outcomes and the structures and processes that are related to those results of care.

### The Accreditation and Survey Process Initiative

This initiative, which is the centerpiece of the Joint Commission's Agenda for Change, requires the development of a more precise and objective system for assessing organizational performance. This revised monitoring and evaluation process will have three major components:

- Utilization of severity-adjusted measurements of clinical indicators of quality to support better analysis of care provided to patients, and the identification of organizational characteristics and management activities that most directly affect quality of care.
- Modification of the survey process from one which relies on triennial on-site visits to one which involves an on-going data collection and monitoring system with continuous feedback to institutions about their performance.
- A revised accreditation decision process with the capacity to define more precisely the performance variables of health care organizations according to their compliance with accepted indicators of clinical and organizational performance.

Each of these components is described in more detail below.

### The Use of Clinical Indicators

The Joint Commission intends to formulate a system for more effective and accurate measurement of an organization's performance through the use of clinical indicators which involve a more direct review of patient care. This will require the development of valid and reliable measures of clinical performance. The Joint Commission believes that the fundamental knowledge and methodology necessary to begin defining and measuring indicators of clinical performance are now available.

Clinical indicators do not depict quality of clinical performance directly. Rather they are a means of predictably raising sound questions about the quality of care. Indicators are "flags" or "screens" which highlight the need for problem analysis and peer review, as appropriate. In that sense, indica-

tors are intended to focus each organization's internal monitoring and evaluation process on important aspects of patient care and assist in pinpointing potential quality of care problems.

Use of clinical indicators is in fact currently an element of the Joint Commission requirement for monitoring and evaluating the quality and appropriateness of patient care. Viewed generically, this review process entails:

- defining the scope of care,
- identifying important aspects of that care, i.e., care that is provided in high volume and/or is known to be high risk and/or is known, or suspected, to be problematic,
- selecting indicators that describe general dimensions of the quality or appropriateness of care,
- establishing criteria that represent reasonable expectations of acceptable practice,
- collecting and critically reviewing data,
- identifying problems if they exist,
- addressing systems problems through appropriate actions or referring clinical performance issues for peer review and action, and
- determining whether actions taken have resolved the identified problems.

Unfortunately, there is at present no national consensus as to a uniform set of valid and reliable indicators. What measures have been utilized by individual organizations are often administrative rather than clinical in nature, are focused on technical quality control rather than medical quality assurance, or are oriented toward clinical processes rather than results. By identifying and selecting acceptable clinical indicators, with assistance from expert groups, task forces, medical specialty societies, and accredited institutions, the Joint Commission intends to direct its attention and monitoring activities in the field to the most important aspects of patient care.

**TABLE 1 — Issues Which Could Be Addressed Through Use of Clinical Indicators**

| | *Diagnosis* | *Treatment* |
|---|---|---|
| **Structure** | **Availability of resources for diagnosis (staff, equipment)/ diagnostic protocols** | **Availability of needed therapeutic resources/ treatment plans** |
| **Process** | **Accuracy, timeliness, and technical skill in applying diagnostic protocols** | **Skill and technical quality of therapeutic interventions** |
| **Outcome** | **Correctness of diagnosis** | **Patient's functional or health status/symptom remission** |

**TABLE 2 — Examples of Clinical Indicators**

| *Organization-wide Clinical Indicators* | *Cross-departmental Clinical Indicators* | *Specialty-specific Clinical Indicators* |
|---|---|---|
| **For general application:**<br>• **Nosocomial infection rates**<br>• **Deaths**<br>• **Internal transfers to ICU** | **For surgical departments:**<br>• **Complications**<br>• **Discrepancies in pathology reports**<br>**For medical departments:**<br>• **Drug interactions**<br>• **Neurological impairment at discharge not present at admission** | **For obstetrics department:**<br>• **Blood loss >500 ml.**<br>• **Fourth degree tears**<br>• **Eclampsia** |

Critical clinical indicators, whether aggregated rates or single sentinel events, will be established to monitor diagnostic and treatment activities as shown in Table 1. For high volume and/or high risk and/or potentially problematic care, indicators will be selected which have relevance for organization-wide review, for cross-department review, or for specialty-specific review. Several examples of each type are presented in Table 2 *for illustratiave purposes only.*

### Severity Adjustment Methods

If cross-organizational comparisons of clinical indicator data are to be applied equitably, appropriate adjustment for differing severity of illness is clearly required.

Case complexity or severity of illness adjustment techniques should allow the Joint Commission to develop methods to reduce the confounding effect of relevant patient characteristics upon measures of performance across institutions. With appropriate control for patient covariates, each organization will be able to compare its indicator findings to normative data from other providers with minimal bias consequent to patient variables.

It is anticipated that different severity adjustment methods may be required to take into account the correction factors that arise in various settings of care (ambulatory, hospice, nursing home) or in various hospital services (e.g., emergency unit, surgery, ICU). With assistance from experts in the field, the Joint Commission intends to investigate techniques currently in use and then select, modify, or create methodologies as needed to address this area of complexity.

### Organizational Assessment

While the intent in the area of patient care assessment is to add a valid clinical evaluation component to the Joint Commission accreditation process, the intent in the organizational arena is to revise and improve the Joint Commission's "traditional" standards by introducing the concept of intra-organizational indicators. At this time, two inter-related approaches for enhancing the quality or organizational assessment seem feasible.

One approach would focus on identifying those administrative and management activities that are believed (in light of expert opinion, experience, and/or organizational research findings) to influence quality of patient care most directly. This would essentially involve operationalizing "effective health care management" via accreditation standards and survey procedures that address the management characteristics of planning, resource allocation, leadership, evaluation, and other characteristics which demonstrably affect quality of care. As with clinical phenomena, quality of organizational performance would be monitored through indicators of structure, process and outcome.

A second approach, which is undergoing further refinement, would be directed towards gaining a better understanding of the implications of organizational restructuring and the functional realignment of health care at the community level.

### Design of an Ongoing Monitoring System

To the extent that clinical and organizational indicators are demonstrated to be sound, an ongoing monitoring system should serve to embed these well-chosen measures in institutional culture on a national basis.

Data relative to specified indicators would be routinely and continuously collected by departments throughout the institution, an activity which should be occurring now under current quality assurance standards. At regular intervals throughout the period of accreditation, clinical and organizational data would be submitted to the Joint Commission either in writing, or by PC diskette, or by data tape, or perhaps even by modem. Periodicity of this transmission is yet to be established in light of cost, feasibility, and utility considerations.

**"The Joint Commission intends to formulate a system for more effective and accurate measurement of an organization's performance through the use of clinical indicators which involve a more direct review of patient care."**

Upon receipt of clinical data, the Joint Commission would process the information and provide timely feedback to the health care facility as additional input to its ongoing self-monitoring process. This cyclical collection and reporting of data would permit feedback of three general types, each involving an associated comparison of interest:

- The organization could promptly compare its performance to internal expectations as an "early warning system."
- The organization could also compare its performance to external expectations. Such external expectations would be based on national performance standards and criteria which would include sufficient flexibility to permit application at the local level. This "criterion-referenced" feedback would reflect the use of professional value judgments concerning acceptable levels of performance.
- The Joint Commission could analyze the indicator data and provide "norm-referenced" summaries. Each organization would then see its standing relative to the distribution of indicator data from similar institutions or hospitals within a region or relative to the experience of all hospitals. The same approach would apply to nursing homes, surgicenters or other health care organizations.

However the details ultimately work out, this type of on-going interactive system would be more data intensive for both the provider and the Joint Commission. Each organization should be able to build on its existing monitoring methods in a manner that works effectively and efficiently for that organization. In addition, as the implementation phase of this project approaches, the Joint Commission intends to provide technical assistance as needed to smooth the transition for health care organizations.

The net result should be a review process whose focus is more clinical, which better addresses the adequacy of responses to problems, and which in the aggregate is substantially more results-oriented.

### The Revised Survey Process

At a given point in the ongoing cycle of data transmission and feedback, an on-site survey will occur. Although some content of the current survey process undoubtedly will be retained, future reviews will be significantly affected by the focus on clinical and organizational indicator data.

With knowledge of the organization's longitudinal data-based track record, the surveyor would have a responsibility to validate the quality (reliability and validity) of the indicator data. Further, using institutional performance data which have flagged potential problem

areas, the surveyor should validate the substance of the problem analysis and the validity of findings. The effectiveness of actions taken to resolve problems would also be assessed.

The surveyor himself would assume the role of clinical or organizational "diagnostician." When indicator data point toward less-than-desired performance which has not been addressed, the surveyor would engage facility staff in a problem-solving process to "get behind" the numbers. In this model, emphasis is placed on the use of quantifiable screening criteria to identify and resolve problems. The performance data are not an end in themselves.

### Implications for Accreditation Decision-making

The application of a process utilizing clinical and organizational indicator data may well lead to modification of Joint Commission accreditation procedures. With several years of development, testing, and evaluation yet to unfold, it is difficult at this early date to state with any certainty how accreditation decision-making will be affected.

### Field Involvement in the Developmental Process

A developmental program as ambitious and far-reaching as that set forth above will not be accomplished in the near future, nor will the program be successful without continuous and extensive input from those involved in Joint Commission accreditation programs.

The developmental process anticipates a measured progression from small-scale pilot tests to larger-scale field trials to incremental implementation with careful evaluation throughout. Full implementation is targeted for the early 1990's beginning with hospitals — whose experience with indicator data is broader and whose data systems tend to be more sophisticated — and then widening to include psychiatric, ambulatory, and hospice services.

A somewhat different sequence of events is likely to occur for the long term care and home care survey processes. For a variety of reasons, there is a compelling need to develop clinical indicators and integrate their use into these surveys on an earlier schedule than for the other programs. This will occur in 1987 and early 1988, with development of the continuous monitoring system occurring in subsequent years. Both the complexity and the importance of these quality assurance initiatives dictate that the Joint Commission move prudently but with deliberateness through its developmental agenda.

**"Input, guidance, and critique by health care providers will be critical to the success of the accreditation and survey initiative of the Agenda for Change."**

Input, guidance, and critique by health care providers will be critical to the success of the accreditation and survey initiative of the Agenda for Change. The Joint Commission will seek to understand and take account of the field's capabilities and its perceptions in shaping the revised monitoring process. During the developmental phase field involvement will take a variety of different forms including, but not necessarily limited to, the following:

- participation in a poll of all accredited organizations regarding data system capacities, clinical and organizational indicators now in use, and severity adjustment methods applied if any,
- involvement as pilot test sites,
- evaluation of indicators used in pilot tests,
- voluntary submission of indicator data to the Joint Commission during "dry runs" of the system, with feedback of analyzed indicator data,
- involvement as field trial sites, and
- review of proposed indicators prior to implementation in the accreditation process.

Throughout this engagement with the health care community, an iterative process of back-and-forth communication will be employed. These discussions will focus on assessing and evaluating the revised monitoring and survey processes from the perspectives of:

- utility and conceptual soundness,
- feasibility and practicality,
- data validity and reliability,
- system flexibility and adaptability, and
- cost and value.

### Summary

This historic re-direction of the Joint Commission's survey and accreditation processes is made possible by the evolution of health care assessment methods and technologies, but it is fueled by the Joint Commission's determination to promote quality of patient care through the most cost-effective means available. Though the challenges are great and the developmental obstacles to overcome are many, there is substantial value in a system that can accurately monitor quality of care and report meaningful findings to those involved in and concerned about health care.

The Agenda for Change will put the Joint Commission in a far more supportive and facilitative mode in helping health care organizations meet the responsibility for quality of care that the public, not the Joint Commission, has imposed on them. We're really talking about people making better decisions based on better information. That's where we need to be, and that's the course the Joint Commission has embarked upon. ■

# Georgia Doctors Help Medically Indigent

*Jack F. Menendez, M.D.*

HEALTH CARE for the medically indigent in our state has become an issue of critical concern that must be addressed. Competition in health care, cost containment efforts by government, third-party payors and private businesses, liability troubles, lack of funding at the state and county level, and other restrictions on medical care delivery have created undue pressure on health care providers, thereby limiting their ability to fully meet the needs of the medically indigent.

The Medical Association of Georgia has originated various activities to help the medically needy. In 1982, MAG developed "Operation Care," a physician referral service for unemployed Georgians who had lost their health care benefits. In 1983, MAG physicians formed the Maternal and Infant Task Force to deal with pregnancy and prenatal care problems of indigent patients.

MAG has also supported numerous legislative initiatives such as expansion of the Aid to Families and Dependent Children program and, in 1984, the creation of the Hospital Care for Pregnant Women Act to aid indigent pregnant women in active labor even if their deliveries took place in a neighboring county hospital. Additionally, MAG physicians supported enactment of the Hospital Care for Nonresident Act which has yet to be funded by the General Assembly.

As the medically needy population began to grow, and their needs became greater, MAG physicians responded by forming a Committee on Medical Care for the Disadvantaged. In view of the fact that access to medical care for the indigent is not solely a medical problem, but a societal one as well, the Committee membership encompassed a myriad of involved and concerned interests.

***As the medically needy population began to grow, and their needs became greater, MAG physicians responded by forming a Committee on Medical Care for the Disadvantaged.***

In an attempt to define individuals who are medically indigent, the Committee confined its attention to that population which is uninsured or underinsured and presently uncovered by publicly funded programs. It was decided that focus would include three principal areas:

1. Professional Association and Business Initiatives;
2. Individual practitioner activities and strategies; and
3. Legislative or other public sector proposals.

The Committee worked hard all year, hearing testimony, studying documents and findings, and developing a proposed plan of action. Finally, in April, a list of recommended strategies was submitted to the delegates at MAG's Annual Session last April and the following items were supported by the House of Delegates:

- Development of a state policy of medical indigent care funding.
- Appointment of a Governor's task force to study the problem of providing health care for indigents to continue the efforts of the 1984 Joint Hospital Care for the Indigent Study Committee.
- Maximum expansion of the state Medicaid program to include indigent populations not presently covered.
- Reaffirmation of MAG's policy that no patient in Georgia be denied medical care for lack of funds.
- Urging of Georgia physicians to continue caring for medically indigent patients whether or not they are covered by government programs, insurance, or other third party payment plans.
- Encouragement of MAG members and other employers to provide health insurance coverage for all

Dr. Menendez is President of the MAG. This editorial appeared in a slightly shorter version in the May 17, 1987, FORUM section of the *Atlanta Journal and Constitution* under the title, "Health care for medically indigent at critical stage."

their employees and urge insurance companies to facilitate this outcome.

- Continuation by MAG in collecting and analyzing data relating to health care for Georgia indigents, and
- Appointment by MAG of an Indigent Care Committee to carry out the directives of MAG's governing bodies as well as future recommendations submitted by the Ad Hoc Committee on Medical Care for the Disadvantaged.

Although all of these recommendations have merit, the most significant problem that remains is the funding of such actions. State Senator Ed Hine (D, Rome) indicated in his special editorial printed in the *Atlanta Journal and Constitution* on April 26, 1987, that the medically indigent account for 15 percent of the state's population. Just to increase state funding for Medicaid to cover the entire medically indigent population could cost almost three times the state's current Medicaid budget. Therefore, cost-effective alternatives must be found.

The formation of a gubernatorial study committee would be an excellent method to develop funding proposals. The viable funding alternatives the committee would probably review include the formation of an indigent care pool supported by any number of funding alternatives, such as a tax on cigarettes and alcohol or an increase in sales tax.

The fact is, Georgia citizens are currently paying these costs in the form of a "hidden tax." For example, hospitals and the medical providers treating indigent patients are often forced to increase charges to those with insurance or cash to cover the cost of indigent care. This, in turn, causes health insurance premiums to increase. It has been estimated that up to 30% of your insurance premium pays for services received by indigents. Unfortunately, such "hidden taxes" do not allow for proper resource allocation to address the problems, nor does it provide public accountability.

***The formation of a gubernatorial study committee would be an excellent method to develop funding proposals.***

MAG realizes, however, that simply funding an indigent care program is not enough. Without proper education, the indigent population will continue to grow and their medical needs will become harder to fulfill. Much of the high cost of indigent health care is due to the fact that these patients delay getting care until their problems become too serious to go unattended. This type of care is extremely costly and often extensive.

We strongly agree with Senator Hine's statement that much of this cost could be reduced by increased emphasis on preventive health care. In view of this need, MAG physicians are in the process of developing a Healthy Lifestyles/ Preventive Health Campaign. The primary objective of the program is to promote healthy lifestyle choices among adult and adolescent Georgians. Our motivation is that teaching people how to live healthier lives is the best way to keep health care costs down and alleviate some of the major causes of disease and death in our state.

Additionally, some of our county medical societies have already undertaken indigent care programs of their own. The Medical Association of Atlanta has developed a program for the homeless through which they can obtain needed medical care. The MAG continues to encourage responsible community activities such as these.

Since its inception in 1849, MAG has worked to make care available to anyone who needs it. Unfortunately, the problem has gone beyond what physicians alone can do. The state, the counties, hospitals, businesses, and the public must work together to try and solve this serious threat to the health of a large portion of our society. As Senator Hine said, "(the problem) can be solved fairly and equitably and in a manner to promote good health, not just the cure or containment of bad health." As the state's physicians, we are here to see that this is carried out.

# Frozen Autologous Blood — Not Generally Recommended

*Alfred J. Grindon, M.D.*
*Director, Blood Services*
*American Red Cross, Atlanta Region*

*Jane B. Jennings, M.D.*
*Medical Director, Blood Services*
*American Red Cross, South Atlantic Region*

***The American Association of Blood Banks has stated that "Long-term frozen storage is usually not necessary and generally not recommended. . . . The AABB therefore does not encourage the long-term frozen storage of blood in the absence of a demonstrated medical need."***

RECENT PUBLIC AWARENESS of the hazards of disease transmission with transfusion have led to an increasing medical interest in autologous donation and transfusion.[1, 2] Blood bankers have long-supported predeposit autologous programs, because autologous blood represents the safest product a patient can receive. Autologous transfusion is a reasonable approach to reduction of post-transfusion Non-A, Non-B hepatitis. In Georgia, Red Cross Blood Centers have provided this service for many years. The number of autologous donations given through local Red Cross blood centers has more than doubled in the last year, and donations are now accepted at many blood drives in the community.

Autologous transfusion can be used where the patient is otherwise healthy and can serve as a blood donor, and where the blood donation is for operative procedures where transfusions are regularly given.[3] These conditions are often used in orthopedic and plastic surgical procedures. Patients scheduled to undergo such procedures can donate several units of blood beforehand and have this stored in the liquid state for subsequent transfusion if needed. Other types of surgical procedures where blood is not regularly transfused are less appropriate, since in these cases blood is either not transfused at all, or if needed, several units are given. Having a unit of autologous blood available would not reduce the frequency of homologous transfusion. It is important to note that the benefit of autologous transfusion is measured not in terms of autologous units drawn or autologous units transfused, but homologous units *not* transfused.

Autologous blood will never represent the bulk of transfusions given, but currently such units represent 1 to 1.5% of all units distributed from our centers for transfusion and could well increase to as much as 3 to 5% of all transfusions given.

In many parts of the country, interest has developed in the long-term frozen storage of blood for indeterminate future use. These programs have often been developed by entrepreneurs and promoted with the use of public advertising, some of which is incomplete or misleading, since it extols the virtues of autologous transfusion, then applies them by extension to frozen autologous blood storage (FAS). Specialists in transfusion medicine have generally decried the use of FAS, because blood frozen without a specific transfusion need is unlikely to be used, and if blood is needed in an emergency, it is unlikely that blood stored in a frozen state could be prepared in a short enough period to be useful.[4] If blood is needed for scheduled elective surgery, it is

likely that liquid autologous storage as discussed above would be equally useful and substantially less expensive. The American Association of Blood Banks has stated that "Long-term frozen storage is usually not necessary and generally not recommended because blood stored in this manner is not readily available, particularly at the time of an emergency. The AABB therefore does not encourage the long-term frozen storage of blood in the absence of a demonstrated medical need."[5]

Both the Atlanta and the South Atlantic Red Cross Regions offer frozen autologous storage at cost for those patients who feel this is important for them; however, we provide information that will allow the donor to be fully informed before consenting to donation and storage. Most donors, when made aware of the facts, have seen no need to store their blood in the frozen state.

We urge consideration of autologous donation and transfusion where appropriate in the liquid state, or, if there is a specific need, in the frozen state. We feel, however, that FAS without a specific transfusion need is not in the best interest of the patient, the physician, or the health care system.

***These programs (for long-term frozen storage of blood) have often been developed by entrepreneurs and promoted with the use of public advertising, some of which is incomplete or misleading, since it extols the virtues of autologous transfusion, then applies them by extension to frozen autologous blood storage.***

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**PREGNANT MOTHERS: PLEASE DON'T SMOKE!**

Here are three good reasons to quit smoking now:

1 Smoking retards the growth of your baby.

2 Smoking increases infant mortality.

3 Your family needs a healthy mother.

Don't smoke.
For your baby's sake.
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AMERICAN CANCER SOCIETY

# Other Houses, Other Speakers

*C. Emory Bohler, M.D., Brooklet*
*Family Practitioner*
*Chairman of AMA Delegation*
*Past President of MAG*

THE FIRST ANNUAL SESSION of the Medical Association of Georgia that I attended was in approximately 1957 in Macon. I did not go to listen to the learned debate on the floor of the House; I went because of my interest in the Clinical Session.

The Clinical Session and the House of Delegates met jointly until 1974. Prior to 1974, pharmaceutical companies paid rent for exihibition booths at each Annual Session. We were constantly belabored by MAG officers and staff to please visit the exhibits because "they are paying for your meeting." The 1973 House of Delegates approved division of the Annual Session into a business and a scientific session each year. Disinterest on the part of pharmaceutical companies was one of the primary reasons for the division.

Thomas W. Goodwin of Augusta was Speaker of the House from 1955-1960. Tom had little patience with prolonged oratory or discussion other than his own! He later became President of the MAG.

J. Frank Walker of Atlanta was Speaker from 1961-1968. A brillant man and a superb parliamentarian, Frank became Vice Speaker then Speaker of the American Medical Association House of Delegates and would have become President of American Medical Association but for his severe illness and untimely death.

Harrison L. (Jack) Rogers was the Speaker of MAG's House from 1969-1974. Jack also became Vice Speaker and Speaker of the AMA House and then President of the AMA. Once when referred to by someone in the Medical Association of Georgia House of Delegates as "our silver tongued speaker," Jack walked around with his tongue protruding from his mouth for at least half the session!

L. C. (Buck) Buchanan of Decatur was Speaker of MAG's House from 1975-1980. Buck ran a tight and efficient ship. At the end of each Session, he gave a "Nit Pickers Award" to a deserving member. The award was a large brightly painted piece of cardboard appropriately inscribed. Michael Glucksman (deceased) from Brunswick won it 2 years in succession.

Jack Menendez of Macon was MAG's Speaker after Buck. Jack has been one of our most conscientious and hard working speakers and ran a smooth house.

The House of Delegates is made up of hard working physicians who meet once yearly to consider the Medical Association of Georgia's problems and to decide the course of action for the year. Over the years, MAG's House has spent more time arguing over dues increases and where the money went than any other subject. We have always seemed to do the right thing for the MAG, however. In my opinion, we have the best over-all organization in the country, and I am well acquainted with most of them.

I am proud to have been part of this organization.

# A Clinical Opportunity for Smoking Intervention

You can play a special role in reaching smokers. Encouraging parents not to smoke can improve the health of the entire family.

Take a few minutes to explain that children of parents who smoke are often more prone to respiratory infections. Tell them that young children of parents who smoke are more likely to become smokers themselves.

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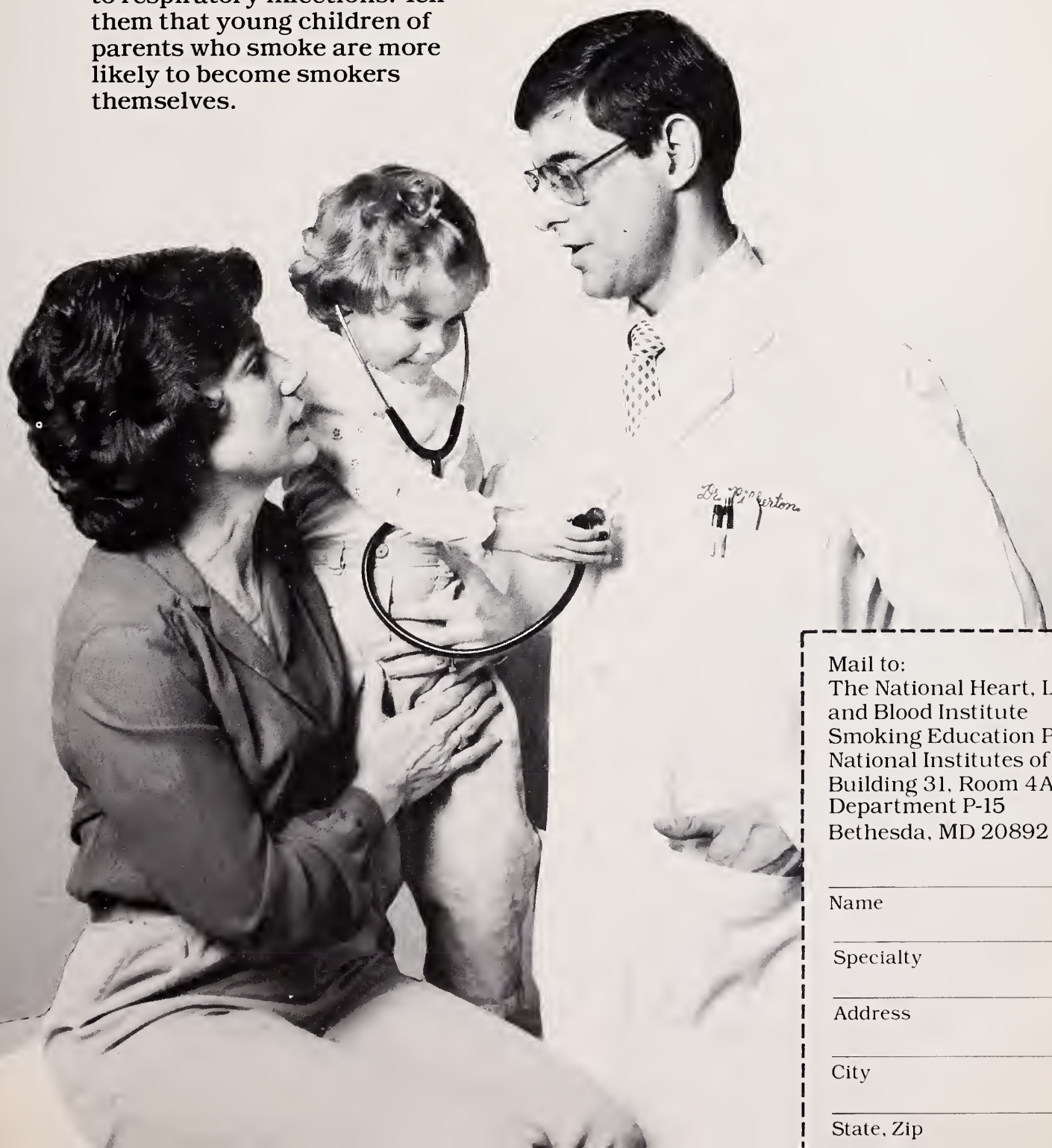

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News from DISTA about a new dosage form of cephalexin

ANNOUNCING NEW

# Keflet™ TABLETS

## cephalexin

## All the advantages of cephalexin in a convenient tablet form

- Backed by over 15 years of clinical experience
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- May enhance patient compliance, particularly among the elderly
- Tablet dosage form may be appreciated by patients of all ages

### NEW Keflet Tablets are available as:

250-mg Tablets

500-mg Tablets

Keflet is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-sensitive patients.

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**Brief Summary. Consult the package literature for prescribing information.**
**Indications and Usage:** Keflet™ Tablets (cephalexin, Dista) are indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Respiratory tract infections caused by *Streptococcus pneumoniae* and group A β-hemolytic streptococci (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. Keflet is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of Keflet in the subsequent prevention of rheumatic fever are not available at present.)

Otitis media due to *S pneumoniae, Haemophilus influenzae*, staphylococci, streptococci, and *Neisseria catarrhalis*

Skin and skin-structure infections caused by staphylococci and/or streptococci

Bone infections caused by staphylococci and/or *Proteus mirabilis*

Genitourinary tract infections, including acute prostatitis, caused by *Escherichia coli, P mirabilis*, and *Klebsiella* sp.

*Note*—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

**Contraindication:** Keflet is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflet.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile*. Other causes of colitis should be ruled out.

*Usage in Pregnancy*—Safety of this product for use during pregnancy has not been established.

**Precautions:** *General*—Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflet may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Keflet should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflet, a false positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

*Usage in Pregnancy—Pregnancy Category B*—The daily oral administration of cephalexin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalexin during pregnancy in humans has not been established.

Cephalexin showed no enhanced toxicity in weanling and newborn rats as compared with adult animals. Nevertheless, because the studies in humans cannot rule out the possibility of harm, Keflet should be used during pregnancy only if clearly needed.

*Nursing Mothers*— The excretion of cephalexin in the milk increased up to 4 hours after a 500-mg dose; the drug reached a maximum level of 4μg/mL, then decreased gradually, and had disappeared 8 hours after administration. Caution should be exercised when Keflet is administered to a nursing woman.

**Adverse Reactions:** *Gastrointestinal*—Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

*Hypersensitivity*— Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported.

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# What About the Social Security Medical Consultant?

Bernard P. Wolff, M.D., William G. Hamm, M.D.

***The following article is by two retired Atlanta practitioners who, after long periods of private practice, signed on as Social Security Disability Medical Consultants. It is hoped to shed some light on the disability program, especially as seen from the physician's viewpoint.***

### Introduction

As a result of the enormous escalation in the private and clinic physician's risks and expenses, many have elected to seek alternatives. One of these is to join the medical staff of state or federal Social Security disability programs. Though most doctors have a vague idea and a nebulous concept of the duties of the Social Security medical consultant, very little is known outside the fraternity of the consultants themselves.

The following brief report is by two retired Atlanta practitioners who, after long periods of private practice, signed on as Social Security disability medical consultants. Both served in the State and Federal offices and became familiar with the physician's role in these disability programs. Both retired voluntarily. It is to be understood that the forthcoming remarks are not official statements of the Social Security Administration, but are composed of opinions generated by experiences in the federal and state disability agencies in Atlanta. It is hoped to shed some light on the disability program, especially as seen from the physician's viewpoint. The opinions are uniquely the authors' and may not reflect those of other physicians in the program.

Dr. Wolff is a retired internist (pulmonary), and Medical Consultant, Retired, Disability Determination, Georgia Department of Human Resources (DHR) and is Past President of the Atlanta and Georgia Lung Association; and Dr. Hamm is a Clinical Professor of Surgery, Plastic, Retired, Emory University School of Medicine, Rear Admiral, U.S. Navy Reserve MC, Retired, and Medical Consultant, Retired, Disability Determination Unit, DHR. Send reprint requests to Dr. Wolff, 2643 Dellwood Dr., Atlanta, GA 30305.

### Determining Disability — The Physician's Role

The Social Security Act was voted on by Congress and became a law after being signed by the President of the United States. Because of its legal status, the regulations governing disability cannot be changed. Since the original program was implemented, disability is defined as "inability to engage in *any* substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for

a continuous period of not less than 12 months."

A handbook sets forth the medical evaluation criteria and describes impairments in terms of symptoms, signs, and laboratory findings that are presumed to be severe enough to prevent an individual from working for a year or longer. Additionally, some impairments which do not exactly meet a listing in the handbook but have specific findings that are medically equivalent to the listing in severity are said to "equal the intent of a listing."

***. . . the world of numbers, initials, and abbreviations . . . is a whole new language that seems to be the special delight of all government workers, including old and new physicians.***

Gradations of severity that are partially disabling are rated by set rules of residual functioning capacity which may be disabling because of age, lack of education, combinations of non-listing impairments, specialized occupations, or mental problems. A vocational specialist, not a physician, is available to determine the amount of disability resulting from these factors.

The above stipulations form the basis of disability determination especially as pertains to the physicians. These may be changed from time to time when new and incompletely understood conditions (such as AIDS) appear on the medical scene. These are usually "equaled" to a previous listing until further information is forthcoming.

A disabled wage earner (Title II) or welfare recipient (Title XVI) obtains financial benefits under a process set up under the Social Security Act. Application to a Social Security branch office is filed through a trained worker who obtains information as to age, occupational history, details of education and work experience, as well as the nature and details of the alleged disability. If the claim appears eligible, it is sent to a State agency where an adjudicator (trained worker) obtains all social and medical evidence available. If the medical evidence is inadequate to make a decision, a consultative examination is requested of a Social Security-approved physician or from physicians who have attended the claimant in the past. A set fee is given for these services and, at the time of request, limitations are stated, most of which involve risks to the claimant such as hazardous treadmill testing, cardiac catheterization, and tissue biopsy. Invasive testing is never authorized. At the same time, reports of these tests, done independently of Social Security, are greatly valued. Tests not in the file may be requested by the consultant physician provided they conform to Social Security rules. For instance, pulmonary function tests, descriptions of chest pain, graded exercise tests, and others are not acceptable unless they conform to the Social Security requirements.

***In both State and Regional areas, no medical training per se is given, but there are manuals explaining ways of applying disability.***

When enough evidence, medical and otherwise, is obtained, the case is reviewed by an agency physician qualified to judge that particular branch of impairment. He assigns a rating according to accepted terminology and a code peculiar to Social Security. A common example of a physician's rating could be "Ischemic Heart Disease: 414, Meets 404B1 — Diary 1 yr." This case will then be sent from the State to the Regional office (Federal) where a careful review is made of the entire record. If the Regional Consultant agrees with the State, the record is sent to the Central Office for final review. If the State cannot make a decision, more information is requested. If a partial disability is given, an R.F.C. (residual functional capacity) form is completed with appropriate coding. At the Regional level, if the medical consultant disagrees with the State, a code indicating either a mistake or inadequate evidence is given, and the chart is returned to the State for more development. The same arrangement applies to the Central and Regional levels. In any case, the mistake, if proven, is recorded against the guilty doctor and agency.

The R.F.C. is explained in writing by the involved physician and mistakes or disagreements are also explained in a detailed write-up by the disagreeing physician. These may be rebutted by the State or Federal agency. When no agreement is reached, the chart is sent to the Central Office for a final opinion. All allowed disability claims are reviewed after 2 years.

### Regional Versus State Agencies

The above is a crude and sketchy outline of the principal role of the physician in the Social Security program, but there are other duties. These consist of medical lectures to the adjudicators covering various diseases, with particular emphasis on the Social Security disability program. This is an ongoing duty in the State agency because of the much larger number of State employees as well as a larger turnover than the Federal. Also, many of the

full-time employees at the Federal agency were formerly State workers. Occasional lectures occur at the Regional Office monthly medical meetings of both Regional and State physicians. Rarely, a combined meeting is held. Both are primarily used to explain agency problems and introduction of new programs. A new physician rarely benefits from these because of the propensity of government workers to use a torrent of initials. Recently, a meeting was held on CDR cases which require a 3094 Q.A. form. These may be M.I.E., M.I.N.E., M.I., etc. Almost every sentence was full of initials which we all knew would become part of the Social Security mystique, but at the same time detracted from the intent of the lecture.

***The disability determination agencies are completely different from medical or surgical practice, but have become an integral part of the medical sciences.***

The State requires intensive training of new physicians prior to rating the cases. This was a full 8-hour day, 5 days a week for 2 weeks. Most of this was done by seasoned adjudicators or physicians and was an initiation into the world of numbers, initials, and abbreviations. The latter is a whole new language that seems to be the special delight of all government workers, including old and new physicians. Only after several years is one able to converse freely in terms of 3094, 416, CDR, M.I.E., M.I.N.E., R.F.C., P.O.M.S., ID, etc., ad infinitum.

The Regional Office has less training. It is more of instruction, one on one. In the beginning, the variety of forms with their codes is bewildering but then all of a sudden they do make sense

In both State and Regional areas, no medical training per se is given, but there are manuals explaining ways of applying disability. Periodically, rules and regulations are changed. Some changes concern new laws, others (such as AIDS) direct methods of judging and rating. These are discussed in monthly or special meetings of physicians and are necessary to keep up with the frequent changes in format.

The State seems to maintain a higher level of regard and respect for her physicians than the Regional Office, where there is less formality and a distinct feeling of restriction to the business at hand with your nose to the grindstone at all times. This is epitomized by having to punch a time clock in and out for any break from work.

On the other hand, there is a greater sense of togetherness and loyalty among the doctors at the Regional. Overall, the physicians at the Regional and State are hard workers, trying to do a good job in a strange environment and with minimal creature comforts.

The disability determination agencies are completely different from medical or surgical practice, but have become an integral part of the medical sciences.

Physicians who have engaged in the practice of medicine have close personal contact with patients, and this is absolutely essential to arrive at a course of action which is based on his opinion. In contrast, the Social Security physician mainly bases his assessment on existing rules and regulations.

*"The treating physician is neither asked nor expected to make a decision as to whether the patient is disabled." Disability Evaluation under Social Security, page 3, pp. 2.* ■

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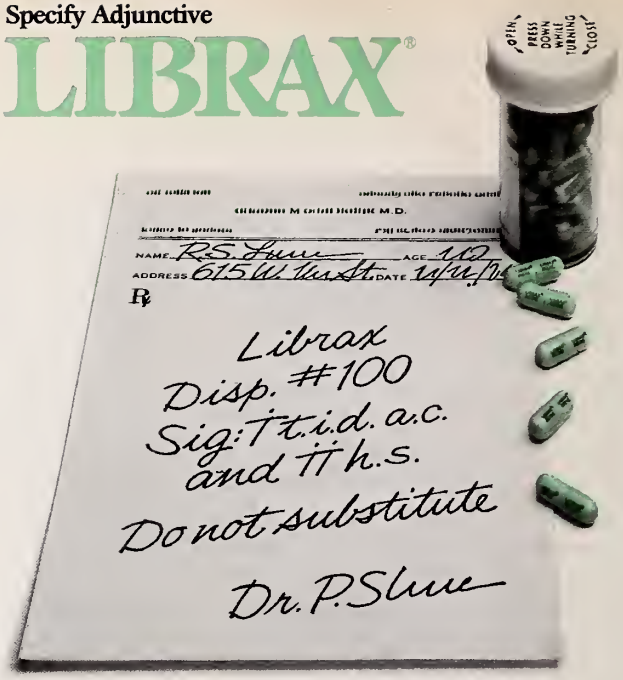


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# Neoadjuvant Chemotherapy of Cancer

*Julian L. Lokey, M.D.*

THE TRADITIONAL ROLE for chemotherapy in the management of cancer has been in the palliation of locally advanced or metastatic disease or as a postoperative adjuvant designed to eradicate micrometastatic disease. Recent trials have produced encouraging results in a variety of malignancies utilizing a brief, intensive course of chemotherapy prior to definitive local therapy. This therapeutic concept has been variably termed neoadjuvant, protoadjuvant, cytoreductive, inductive, or preoperative. In the classical treatment format, remission is induced by surgery and consolidated by chemotherapy and/or irradiation. In the neoadjuvant approach, the initial cytoreduction is accomplished by chemotherapy, with consolidation of control being provided by surgery, radiotherapy, alternative chemotherapy, or some combination of these modalities.

## Human Tumor Cell Kinetics

Understanding the rationale for neoadjuvant chemotherapy requires a review of human tumor cell kinetics. Malignant cells adhere to Gompertzian growth kinetics whereby the fraction of actively dividing cells decreases as tumor mass increases. Small tumors have a large proportion of dividing cells but paradoxically grow slowly because the absolute number of dividing cells is relatively small. Tumors of intermediate size (e.g., Stage III locally advanced breast cancer) grow faster than either very small or very large tumors of the same type. For this reason, intermediate-sized tumors may regress fastest in response to chemotherapy, even though small tumor masses (e.g., Stage II breast cancer post-mastectomy) experience the greatest fractional cell kill. The classical adjuvant setting is a two-compartment model, with compartment I being local disease and compartment II being regional plus distant disease. Rapid ablation of compartment I (e.g., mastectomy) increases the growth fraction of compartment II. This may be useful therapeutically, since rapidly growing tumor populations are more chemo-sensitive. However, the increased mitotic rate in compartment II may increase the risk of development of drug resistant mutants. The timing of adjuvant chemotherapy relative to definitive local cytoreduction is therefore critical. Preoperative or immediate perioperative chemotherapy may provide the best chance for eradication of systemic micrometastases based on these cell kinetic principles. Finally, the use of preoperative chemotherapy may impact favorably on local control, even converting inoperable or marginally operable patients to reasonable surgical candidates. Valuable information is also gained by observation of response of measurable tumor to chemotherapy in vivo which may then be applied to postoperative decision making.

## Results of Clinical Trials

Numerous clinical trials employing neoadjuvant chemotherapy have been undertaken in recent years. Encouraging and interesting results have been seen in the following malignancies: esophageal carcinoma, squamous carcinoma of the anus, head and neck carcinoma, osteogenic sarcoma, carcinoma of the bladder, and breast carcinoma.

The treatment of squamous carcinoma of the esophagus with surgery or radiation therapy has been quite unsatisfactory, with 2-year survival generally less than 10%. Neoadjuvant chemotherapy using 5-Fluorouracil and Cis-Platin has resulted in a high objective response rate with some clinical and pathologic complete remissions.[1] It appears that pathologic complete remission following such therapy does convey improved survival when compared to conventionally treated

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atients. However, the number of atients is relatively small, and the uration of followup is inadequate to ssess impact on long-term survival. or squamous carcinoma of the anus, eoadjuvant use of 5-Fluorouracil nd Mitomycin-C plus irradiation has ıpplanted radical surgery as primary ıanagement.[2] Overall, approximately 0% of patients achieve complete egression of all tumor with this pproach, with long-term disease-free ırvival occurring in the majority.

A major cause for morbidity and ıortality in squamous carcinomas of ıe head and neck has been failure to chieve local control in advanced tages III and IV disease. hemotherapeutic regimens including is-Platin plus 5FU or Cis-Platin lus Methotrexate and Bleomycin can roduce tumor regression in 80% of reviously untreated patients. Twenty forty percent of patients xperience clinical complete emissions, with approximately one alf of these being pathologically onfirmed.[3] Some studies have failed show survival advantage even in sponding patients, and certainly lditional research is necessary. owever, there is increasing vidence that neoadjuvant therapy in tages III and IV disease improves perability and ability to effectively liver irradiation. Complete sponders in most studies appear to ıjoy a survival advantage.

The use of neoadjuvant ıemotherapy (high dose Methotrexate, Adriamycin) has been effectively employed in patients with osteogenic sarcoma. Patients experiencing a good response to neoadjuvant therapy are better candidates for limb sparing surgery. In addition, the ability to assess response of the primary tumor to chemotherapy is of value in planning subsequent postoperative adjuvant treatment. Recent randomized trials have shown a clear advantage for the chemotherapy arms as compared to surgery-alone controls in the management of osteogenic sarcoma.

Several chemotherapy regimens based on Cis-Platin have shown impressive response to locally advanced or metastatic transitional cell carcinomas of the bladder. Neoadjuvant trials of Cis-Platin alone[4] or in combination[5, 6] have demonstrated impressive down-staging of advanced bladder carcinomas, rendering potentially unresectable patients operable for cure.

Locally advanced (Stage III) breast carcinoma and inflammatory carcinoma of the breast have traditionally been associated with a very poor prognosis. Preliminary data from several institutions using a systemic neoadjuvant approach indicate improved 2-year survival and even the potential for long-term disease-free survival.[7, 8, 9]

In summary, neoadjuvant chemotherapy is a concept with both theoretical and clinical advantages. The ultimate goals of this approach are:

A. Reduction of the primary tumor quickly so that definitive surgery and/or radiotherapy can be more effectively employed;

B. The earliest possible treatment of micrometastases to avoid the development of drug-resistant mutants.

Despite encouraging early results, the precise role of neoadjuvant chemotherapy in the management of malignancy remains a subject for additional clinical research.

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# Abstracts From Symposium on Cardiovascular Research: Part I

*On August 8, 1986, the Georgia Affiliate of the American Heart Association held a symposium on Cardiovascular Research. More than 80 physicians and scientists from across the state gathered at the University of Georgia in Athens to present findings of research supported in part by contributions of Georgia residents. The following abstracts are representative of the research investigations discussed at this symposium and are the first of three parts to be presented in the HEART Section.*

FLUORESCENT ASSAY OF LIPID BINDING TO NON-SPECIFIC LIPID TRANSFER PROTEIN.

*J. Wylie Nichols, Department of Physiology, Emory University School of Medicine, Atlanta, GA 30322.*

Since the binding of lipid molecules to non-specific lipid transfer protein (nsLTP) could not be demonstrated previously, it was thought to catalyze the transfer of lipids between membranes by a mechanism not dependent on lipid-protein binding. A sensitive fluorescent technique has been developed in this lab that allows for the quantitative measurement of the binding of lipids to nsLTP. Binding of NBD (7-nitro-2,1,3 benzoxadiazol-4-y1) labeled phospholipids to nsLTP is detected as an increase in fluorescence emission as the NBD-phospholipids transfer from self-quenched vesicles to a hydrophobic site on the protein. Kinetic experiments indicate that nsLTP removes and binds the NBD-phospholipids from the aqueous solution and not from the vesicles directly. The significance of these findings in relation to the nsLTP mechanism of action and physiological significance will be discussed.

SPECIFIC MEMBRANE SITES INVOLVED IN THE CARDIAC EFFECTS OF VOLATILE ANESTHETICS.

*Robert J. Adams, Jack K. Pruett and Wayne S. Mathews, Department of Anesthesiology, Medical College of Georgia, Augusta, GA 30912-0352.*

Volatile anesthetics such as halothane and enflurane depress myocardial contractility and can cause cardiac arrhythmias in susceptable patients. The mechanisms for these effects are not well understood but most likely involve the disruption of cell membrane ion permeability and transport throughout the excitation-contraction/conduction-relaxation (EC/CR) cycle. Experiments have been performed with intact animals (dog), isolated cardiac tissue and purified cardiac sarcolemmal membranes to investigate possible sites involved in the cardiac effects of general anesthetics. Our studies have revealed that enflurane and halothane affect at least three cell membrane sites which are important for the normal electrical and contractile functions of the heart. These include the $Na^+$, $K^+$-ATPase, which maintains the cell's transmembrane electrochemical gradient and cellular excitability; the $Ca^{2+}$ channel, which permits $Ca^{2+}$ influx during excitation to initiate contraction and the $Na^+$/$Ca^{2+}$ exchange antiporter which regulates intracellular $Na^+$ and $Ca^{2+}$ concentrations throughout the EC/CR cycle. The relative importance of these sites in the cardiac effects of volatile anesthetic agents is the focus of ongoing studies and will be discussed in relation to their possible role in the membrane mechanism of general anesthesia.

SODIUM PHOSPHATE COTRANSPORT AND PHOSPHATE COMPARTMENTATION IN HUMAN RED CELLS.

*D. G. Shoemaker, C. A. Bender, and R. B Gunn. Department Physiology, Emory University, Atlanta, GA 30322.*

Influx of inorganic phosphate ($^{32}P$ = 1 mM) into human red cells was

The HEART Section is sponsored by the Georgia Affiliate of the American Heart Association. Those wishing to contribute articles to this Section should send them to Wesley Covitz, M.D., HEART Editor, Section of Pediatric Cardiology, Medical College of Georgia, Augusta, GA 30912.

amined in a high (140 mM) dium ($Na^+$), 10 mM HEPES (N-2-droxyethyl-piperazine-N′-2-ıanesulfonic acid) buffered (7.4) edium at 37°C. Control cells hibited an influx of 2.29 ± 0.08 mole $P_i$/Kg Hb hr with 76 ± 1% this flux being sensitive to the ecific anion transport inhibitor, NDS (4,4′-dinitro stilbene-2′disulfonate), and 84 ± 2% of DNDS insensitive influx inhibited replacing extracellular $Na^+$ with MDG$^+$ (N-methyl-D-glucamine). netic evaluation of this $Na^+$, $P_i$ ntransport pathway determined the for activation by $Na^+$ and $P_i$ to be 9 ± 4 nM and 304 ± 24 uM pectively with a stoichiometry for $^+$:$P_i$ of 2:1. Incorporation of tracellular $^{32}P_i$ into intracellular osphate pools was found to differ rkedly depending on the transport hway used by the $P_i$ to enter the l. Removal of extracellular $Na^+$ s found to inhibit 90% of the $^{32}P_i$ orporated into an aqueous mbrane fraction while the sence of DNDS had no effect on incorporation. This result licates a compartmentation of osphate metabolism in the human l cell.

ILORIDE PERMEABILITY OF OLATED CARDIAC YOCYTES. *M. A. Wallert and Froehlich. Department of ysiology, Emory University School Medicine, Atlanta, GA 30322.*

Myocardial cells from rat ventricle were prepared as suspension of dissociated cells, by perfusing hearts from 250-300 g rats with collagenase and hyaluronidase-containing solutions. The average viability of these cells was 70-75% as determined by their morphology and their ability to exclude trypan blue. These cells maintained their viability for several hours in normal-Ca media at 37°C, losing 3-5% of their viable cells per hour. The ionic contents are the same as expected from intact muscle measurements by others: $K_i$ = 123-131 mM, $Na_i$ = 31-32mM, and $Cl_i$ = 27-30 nM.

We determined the chloride permeability of these cells by means of tracer chloride influx and efflux experiments at steady state. At 25°C, the time constant of tracer Cl loss was 0.05 $min^{-1}$, and at 37°C it was 0.3 $min^{-1}$, in agreement with the tracer efflux measurements by Page and Polimeni with intact rat hearts. These values correspond to flux values of 0.6 and 4 mmol (kg protein × min)$^{-1}$, respectively. Tracer influx experiments at 37°C yielded values of 7 mmol (kg protein × min)$^{-1}$. The origin of this difference is not known but it probably is due to slight differences in the experimental conditions. When fluxes were measured in the presence of inhibitors of anion exchange (DIDS, SITS or DNDS), they were reduced by about 20% for both efflux and influx. These results indicate that the chloride-bicarbonate exchanger is not the major contributor to the chloride permeability of the cardiac plasma membrane.

ARTERIAL BARORECEPTOR REFLEXES ARE MEDIATED BY N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTORS IN CAUDAL VENTROLATERAL MEDULLA (CVM). *Frank J. Gordon, Department of Pharmacology, Emory University, Atlanta, GA 30322.*

The purpose of these studies was to identify CNS pathways and synaptic receptors that participate in central baroreflex control. Rats were anesthetized with urethane, bilaterally vagotomized, paralyzed and respirated. Multibarrel glass pipettes were placed in the CVM depressor area which was functionally identified by micro-injection of L-glutamate (2 nmol, 50 nl). Baroreflex-mediated decreases in arterial pressure of 10-40 mmHg were produced by graded electrical stimulation of the aortic nerve. The GABA agonist muscimol (100 pmol) and the NMDA receptor antagonist D-2-amino-5-phosphonovaleric acid (D-AP5; 2 nmol) abolished baroreflexes following their microinjection into the CVM. Muscimol also eliminated depressor responses to subsequent microinjection of L-glutamate, suggesting that activation of GABA

receptors blocked arterial baroreflexes by generalized inhibition of CVM neurons. In contrast, D-AP5 eliminated baroreflexes without diminishing the vasodepressor action of L-glutamate, kainic acid (2 pmol) or quisqualic acid (2 pmol). Depressor responses to NMDA (10 pmol) were abolished however, confirming the efficacy of NMDA receptor blockade in the CVM. These results indicate that: 1) the CVM contains an obligatory synapse in the central arterial baroreflex pathway, and 2) neural transmission of baroreceptor information in the CVM is mediated by activation of synaptic NMDA receptors.

EVIDENCE FOR A ROLE OF CIRCUMVENTRICULAR NEURONS IN MECHANISMS OF EXPERIMENTAL ESSENTIAL HYPERTENSION. *Diane K. Hartle and Christina Leone, Department of Pharmacology, Emory University, Atlanta, GA 30322.*

Circumventricular organs (CVOs) are specialized regions of the brain lacking in blood-brain barrier. They have been shown to be central sites of action of several blood-borne peptide hormones. We present data consistent with a role for one of these CVOs, the area postrema (AP), in the mechanisms of hypertension in the Spontaneously Hypertensive Rat (SHR). Radiofrequency ablation of AP reduced mean arterial blood pressure (BP) and heart rate (HR) chronically in SHR but not in normotensive Wistar Kyoto rats (WKY). Systemically administered L-glutamate (GLU) (9mg/g body wt, sc) destroyed GLU-sensitive cells within 2 CVOs, the AP and the subfornical organ. This treatment lowered BP and HR chronically in adult SHR but not in WKY. GLU treatment during adolescence prevented the development of hypertension in the young adult period. These data support the hypothesis that GLU-sensitive CVO neurons may be required for the development and maintenance of hypertension and resting tachycardia in the SHR. The cardiovascular circuitry of AP may be of particular importance in SHR hypertension.

INCREASE OF PARASYMPATHETIC INNERVATION IN SYMPATHETICALLY ANEURAL CHICK HEART. *Margaret L. Kirby, Donna C. Conrad, Donald E. Stewart, Department of Anatomy, Medical College of Georgia, Augusta, GA 309012.*

Embryonic chick hearts were made sympathetically aneural by removal of premigratory neural crest over somites 10-20 at 36-46 hours of development. The parasympathetic postganglionic (cholinergic cardiac) plexus was assessed at 12-16 days of incubation using morphological and biochemical techniques. The postganglionic parasympathetic innervation to the heart was increased by 50 to 100% due to both hypertrophy and hyperplasia of the ganglion cells as well as their terminals. Using chimeric quail/chick embryos with precursors of the normal parasympathetic postganglionic neurons replaced in the chick by quail cells, it was shown that the increased population of cholinergic neurons in the heart was an expansion of the normal precursors rather than some extra source. The expanded population did not express an adrenergic phenotype in response to absent adrenergic cardiac innervation. The functional significance of the cholinergic increase in response to absence of adrenergic terminals in the heart is not known.

SYMPATHETIC NERVES PREVENT INCREASES IN CONTRACTILE SENSITIVITY OF RABBIT BASILAR ARTERY CAUSED BY EXTRALUMINAL BLOOD. *Kimberly B. Valenti and Peter W. Abel, Emory University School of Medicine, Department of Pharmacology, Atlanta, GA 30322.*

Despite extensive research, delayed cerebrovasospasm following subarachnoid hemorrhage remains ar important clinical problem. The effects of extraluminal blood on contractile sensitivity of cerebral arteries was studied by injection of blood into the subarachnoid space of rabbits. One, 3 or 7 days later the basilar artery was removed and dose response curves for norepinephrine (NE) and serotonin (5-HT) were obtained in ring segments of arteries studied *in vitro*. Subarachnoid blood caused an increased maximal response to NE and 5-HT but did no change the concentration of drug causing 50% of maximum contraction ($EC_{50}$). The effects of sympathetic nerves on contractile responses were studied by removing the superior cervical ganglia which supply sympathetic nerves to the basilar artery. Sympathetic denervation for 2, 6 or 14 days had no effect on contraction dose-response curves for NE or 5-HT. However, sympathetic denervation followed by subarachnoid blood injection caused an increased contractile sensitivity (decreased $EC_{50}$) and maximal contraction for both NE and 5-HT. When sympathetic nerves are present, increases in contractile sensitivity do not occur, suggesting that sympathetic nerves protect cerebral arteries from blood-induced increase in contractile sensitivity.

VASCULAR REACTIVITY OF EQUINE DIGITAL VESSELS. *Gar M. Baxter, Department of Large Animal Medicine, College of Veterinary Medicine, University of Georgia, Athens, GA 30602.*

Equine laminitis is a crippling disease of unknown pathogenesis. Vascular mechanisms implicated in the condition include vasoconstriction, arterio-venous shunting, and microthrombosis. This study characterized the reactivity of

the digital arteries and veins of normal horses to vasoactive substances purported to be involved in laminitis. Digital arteries and veins from 8 normal horses were cut into 4 mm rings, and placed in 37C Krebs-Henseleit solution aerated with 95% $O_2$-5% $CO_2$. Optimal diastolic tension was determined in the presence of norepinephrine ($10^{-6}$M). Following an equilibration period of 1.5 hours, cumulative dose response curves to norepinephrine serotonin, angiotensin II, and dopamine were determined between $10^{-9}$M and $10^{-4}$M using a force displacement transducer and recorded as changes in grams of force. The mean maximum vasoconstriction produced by norepinephrine at $10^{-5}$M was 8.0 ± 1.2 g for arteries and 18.4 ± 3.6 g for veins. The mean duration of the response to norepinephrine was extremely prolonged (1-1.5 hours) compared to studies in other species. Serotonin produced a response similar in magnitude to norepinephrine (8.6 ± 1.2 g for arteries and 16.4 ± 3.0 g for veins) but shorter in duration. Angiotension II induced a mild vasoconstriction throughout the entire dose range with mean maximum responses of 9.4 ± 2.0 g for arteries and 12.5 ± 2.3 g for veins at $10^{-5}$M. These data should provide a basis for subsequent studies on vessels from horses afflicted with laminitis and for evaluating potential therapeutic agents.

## VASOACTIVE DRUG EFFECTS ON BLOOD FLOW IN INTERNAL MAMMARY ARTERY AND SAPHENOUS VEIN GRAFTS.

*G. Kimble Jett, M.D.; Joseph M. Arcidi, Jr., M.D.; Lynne M. A. Dorsey, BSN; Charles R. Hatcher, Jr., M.D.; and Robert A. Guyton, M.D. The Carlyle Fraser Heart Center of Crawford W. Long Memorial Hospital of Emory University School of Medicine.*

The internal mammary artery (IMA) is a dynamic coronary graft as opposed to a passive saphenous vein graft (SVG). Therefore, potential exists not only for beneficial vasodilation but also for catastrophic spasm of the artery. The purpose of this study was to examine blood flow in the IMA and SVG during infusion of drugs that are commonly used following cardiac operations. A canine right heart bypass preparation allowed precise control of cardiac output, blood pressure, and heart rate which were maintained constant during drug infusion. Both IMA and SVG perfused the same coronary bed by anastomosing then in a Y fashion to a ligated anterior descending coronary artery. Electromagnetic flow probes measured graft flow (with the other graft occluded) before and after 15 min. of drug infusion. The order of drug infusion was randomized and changes were compared with t-tests for paired differences.

All hemodynamic variables were unchanged, except with norepinephrine which significantly increased dp/dt. The results suggest that the canine IMA flow is changed by the drugs commonly used in perioperative management. Epinephrine and nitroglycerin increased IMA flow and decreased SVG flow while nitroprusside had the opposite effect. The vascular reactivity of the IMA must be considered when these drugs are used after coronary revascularization.

**INTERNAL MAMMARY ARTERY**

| *Drug* | *Dose (ug/kg/min)* | *Control (ml/min)* | *Drug (ml/min)* | *%* |
|---|---|---|---|---|
| Phenylephrine | 2.0 | 51 ± 7 | 45 ± 7* | −14% |
| Epinephrine | 0.05 | 52 ± 7 | 59 ± 6* | +16% |
| Norepinephrine | 0.1 | 45 ± 7 | 55 ± 4* | +21% |
| Nitroglycerin | 1.0 | 45 ± 7 | 59 ± 7* | +36% |
| Nitroprusside | 1.0 | 50 ± 7 | 44 ± 7† | −12% |

**SAPHENOUS VEIN GRAFT**

| *Drug* | *Dose (ug/kg/min)* | *Control (ml/min)* | *Drug (ml/min)* | *%* |
|---|---|---|---|---|
| Phenylephrine | 2.0 | 59 ± 9 | 53 ± 7* | −11% |
| Epinephrine | 0.05 | 67 ± 12 | 60 ± 11 | − 9%‡ |
| Norepinephrine | 0.1 | 62 ± 8 | 76 ± 10* | +23% |
| Nitroglycerin | 1.0 | 69 ± 9 | 59 ± 8* | −14%‡ |
| Nitroprusside | 1.0 | 64 ± 9 | 77 ± 7* | +25%‡ |

* $p < 0.01$
† $p < 0.05$
‡ $p < 0.01$ when compared to IMA

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# Managing the Workload in State Mental Hospitals

Ilhan M. Ermutlu, M.D.

According to the National Institute of Mental Health, within the past 3 decades the number of patients in state hospitals in the country decreased from about 560,000 to 120,000. During the same period in Georgia, state supported beds for the mentally ill and retarded were reduced from about 14,000 to 5,190. The phenomenon called "deinstitutionalization" is a hotly debated topic everywhere as the problem of severely and chronically mentally disabled emerged as a serious issue in communities throughout the country. Deep cuts in hospital beds raises serious questions as to the adequacy of institutional programs in the face of increased demand for service. To insure the efficacy of the mental health system for future generations, a realistic appraisal of current problems with a determined effort to solve them is needed.

**The focus of this paper is the institutional programs, as it appears that serious questions are being raised about the effectiveness and mission of present regional hospitals.**

### A Review of Georgia's Past Mental Health Programs

A brief historical review of the development of the mental health program in Georgia may be helpful to establish a realistic perspective of the issues.

Until the mid 1960s, there were two major institutions to serve the Georgia's mentally disabled: Milledgeville State Hospital in Milledgeville and Gracewood State School and Hospital in Augusta. Established in 1837, the "Asylum" in Milledgeville had grown to be the second largest facility in the country, with 12,000 beds. The Gracewood facility had about 2,000 beds for the mentally retarded.

After a series of scandals and media publicity in the late 1950s, the administration of both institutions was transferred from the Welfare Department to the now extinct Department of Public Health by the Governor of Georgia in 1960. In 1963, the Division of Mental Health and Mental Retardation within the Department of Public Health was created to assume responsibility for these facilities. One of the first actions of the new division was to embark on a comprehensive planning effort encouraged and supported by the Kennedy Administration-backed Community Mental Centers Act of 1963.

A planning team was established at the division to coordinate data gathering and community organization activities and to obtain input from all related professional and voluntary organizations as well as other public programs. In 1965, a blueprint of the comprehensive mental health program was presented at the Governor's Conference for Mental Health and a major effort to establish a modern mental health system in Georgia was underway.[1]

The major emphasis in the planning was for the development of community mental health centers with a wide range of services. With the availability of federal funds for construction and staffing of mental health centers, Georgia moved to establish a network of services for the mentally disabled. Even after the diminishing federal dollars, the Georgia General Assembly continued to support the new mental health, mental retardation, and substance abuse services, making it possible for all Georgians to have access to these resources.

The recommendations of the Comprehensive Mental Health Plan for Georgia (1965) also included decentralization of the state mental hospital services and urged the im-

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plementation of a regional hospital concept which called for building seven new institutions in the population centers of the state. These hospitals were to be located in Atlanta, Augusta, Savannah, Columbus, Rome, Gainesville, and Albany. The old Milledgeville State Hospital would serve as a regional facility for the central Georgia communities with a much smaller bed capacity than 12,000 beds. A second retardation facility, the Georgia Retardation Center, was also planned to be built in Atlanta.

**The phenomenon called "deinstitutionalization" is a hotly debated topic everywhere as the problem of severely and chronically mentally disabled emerged as a serious issue in communities throughout the country.**

Even before the new mental health movement in the state, the leadership in the Department of Public Health and the Department of Psychiatry of Emory University School of Medicine had been involved in planning for a training and research facility in Atlanta. The Georgia Mental Health Institute is the result of that effort.

Considering the population of the area, the regional hospital in Atlanta was planned as a 1,000 bed facility to be built in two phases. The first phase of construction included 500 beds, but the second phase of building program was later abandoned. In other locations, the hospitals would have 300-350 beds.

By the mid 1970s, the regional hospital program was in place, with two exceptions. During Governor Jimmy Carter's administration, it was decided to scrap plans for the hospitals to be built in Gainesville and Albany. A temporary measure to depopulate the crowded Milledgeville State Hospital, which was renamed Central State Hospital, cost Albany the new regional hospital.

The state took over an old Veterans Administration facility in Thomasville and a WWII Air Force training camp in Bainbridge to turn them into rehabilitation facilities for chronically disabled patients from Milledgeville. After expenditure of considerable funds to rehabilitate the buildings, it was decided to establish the Southwestern State Hospital at these locations. Eventually this facility became the regional hospital for that part of the state.

The plans for the Gainesville facility never got off the ground in spite of the fact that a parcel of land was being donated by the citizens of Hall County. Instead, the Georgia Mental Health Institute was designated as the regional hospital for Northeast Georgia even though the capacity of the facility was inadequate to handle the demand for service from the service area.

### Current Status of Georgia's Mental Health Programs

The program development activities within the past 23 years should be a source of pride and satisfaction for all who have been involved in them. However, the events of recent years necessitate a close look at the effectiveness and adequacy of the system in the face of new realities.

The focus of this paper is the institutional programs, as it appears that serious questions are being raised about the effectiveness and mission of present regional hospitals. It is fair to remind the reader that state hospitals have never received the kind of support necessary in the history of this nation. The lawsuits and criticism of certain advocacy groups in the past forced the states to upgrade these facilities, but budgetary problems, recruitment difficulties, and inadequate staffing continue to undermine state hospitals. During the early phase of the mental health center movement, there was an active anti-institutional campaign which urged for closing of all such facilities. However, the winds are changing now, and voices are being heard who are speaking in favor of the role of institutional programs in the mental health arena.[2]

During the past several years, the pressure on regional hospitals in Georgia has been on the increase. Not only are the number of cases significant, but the patients admitted are sicker and more problematic. Decrease in state hospital beds resulted in the transfer of thousands of severely mentally disabled to the communities. This population frequently experiences recurrence of their illness or creates crises in their environment requiring return to the hospital. Readmission to the hospital 4-5 times a year is frequent among the population in question. The staff who try to avoid overcrowding in institutions must control admissions and/or resort to a quick turnover of patients. With current staffing guidelines, increased patient load would ultimately lead to lower standards of care, increased violence on the units, and diminished attention to individual cases.

### Factors Adding Pressure to the Georgia System

Ten to twenty admissions during a weekend is not an unusual event in some of the regional hospitals. Then there are cases over which the staff has no control: court cases who cannot be released without judicial permission and cases with disposition problems. Such cases occupy space needed for new admissions. It is reported that Georgia is one of the states with very high utilization rate of state hospitals. At a time when the number of public and private resources in the communities is at an all time high, why are

the public mental hospitals under such pressure? Here are some of the reasons:

1. Out of 5,190 beds in state institutions 2,130 are for the mentally retarded. The remaining 3,060 beds are divided among medical-surgical, child and adolescent, substance abuse, tuberculosis, and veterans units, in addition to adult mentally ill units. The number of beds for substance abuse is 270 and for adult mentally ill is 1,091.[3] The adequacy of 1,091 beds for the adult mentally ill for a growing state like Georgia is seriously questioned.

**At present, all regional hospitals function as emergency and acute care facilities and have very little room for patients who need longer term treatment in an institutional setting (which was their original mission).**

2. One major gap in the Georgia mental health program is the inaccessibility to general hospital psychiatric beds by the public sector clients. According to the figures obtained from the State Health Planning Agency, there were 803 beds in general hospital psychiatric units and 714 beds in private psychiatric hospitals in Georgia in 1984. Very few of public sector patients are treated in these facilities. It is particularly frustrating to know that many of the psychiatric units in general hospitals in Georgia were built with tax money appropriated for community mental health centers, but budgetary problems prohibited utilization of these resources. In fact, the responsibility to deal with acute problems and emergencies should be assumed by the community programs; but without access to inpatient beds in the community, these programs have to depend on the regional hospitals. The original mission of regional hospitals was to care for patients who needed relatively long-term hospitalization. At present, all regional hospitals function as emergency and acute care facilities and have very little room for patients who need longer term treatment in an institutional setting.

3. Lack of sufficient long-term beds in state facilities forced the accumulation of large numbers of severely disabled in the communities, and they need frequent hospitalization, adding to the load of regional hospitals.

4. The population of Georgia is increasing, along with the numbers of handicapped. Unless appropriate measures are taken, public resources in the state will come under heavier pressure as time goes on.

### Some Solutions

What are some of the measures which may decrease the pressure on regional hospitals and prevent substandard patient care in public facilities?

1. There must be closer cooperation between public and private resources to share the work load. For example, some of the Medicaid and Medicare-eligible patients should be treated by the private sector as well as persons with other third party payment privileges. Establishment of mutually acceptable policies and procedures to facilitate referrals between public and private sectors should be carefully considered.

2. The provision of an adequate number of beds in the public sector is a must under present realities. By a creative and flexible approach, certain needs can be met economically and efficiently. Establishing several small, 50-100 bed, extended care facilities with minimal professional staff may offer a reasonable solution to the problem of severely mentally disabled who cannot maintain themselves in the community successfully and need a structured and controlled milieu.

3. An immediate relief for the regional hospitals could be provided if the community mental health centers had funds to purchase service from the general hospitals or private psychiatric facilities for the care of acute and emergency cases. There are 1,517 psychiatric beds in the communities. Even limited use of these beds for emergency cases would have some impact on the utilization of state hospitals.

4. Aggressive advocacy is needed to underline the necessity of a balanced program development in the mental health field, giving equal priority to community and institutional programs. Taxpayers do not get their money's worth if both systems are not functioning equally well.

5. Community residential programs for the mentally ill still remain a high priority item for the mental health system, and more group homes and other similar resources are needed.

In Georgia, we are approaching a critical point regarding the standards of care and personnel morale in our institutions. There are fresh ideas about the role state hospitals can play in the care of the mentally disabled. Prejudiced and extreme anti-institutional ideology has proven to be against the best interest of the mentally ill. We should not wait for media publicity or lawsuits before finding remedies for the problems which are threatening the efficacy of the whole mental health system.

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*(Continued from p. 493)*

and avoids leaving the head embedded. After removal, apply alcohol-saturated cotton to the area for 5 minutes. Liberal application of tick repellent, wearing long sleeve shirts, and tucking pant legs into boots or socks are also recommended. Pets should be treated with tick repellents to prevent transporting ticks into the home environs.

The diagnosis of ehrlichiosis should be considered in patients with a history of tick exposure and a febrile illness with lymphopenia, thrombocytopenia, and abnormal liver function tests and negative RMSF tests. The Office of Epidemiology is very interested in reports of tickborne diseases. To report a case, please call either James Patterson (404-894-6527) or your county health department.

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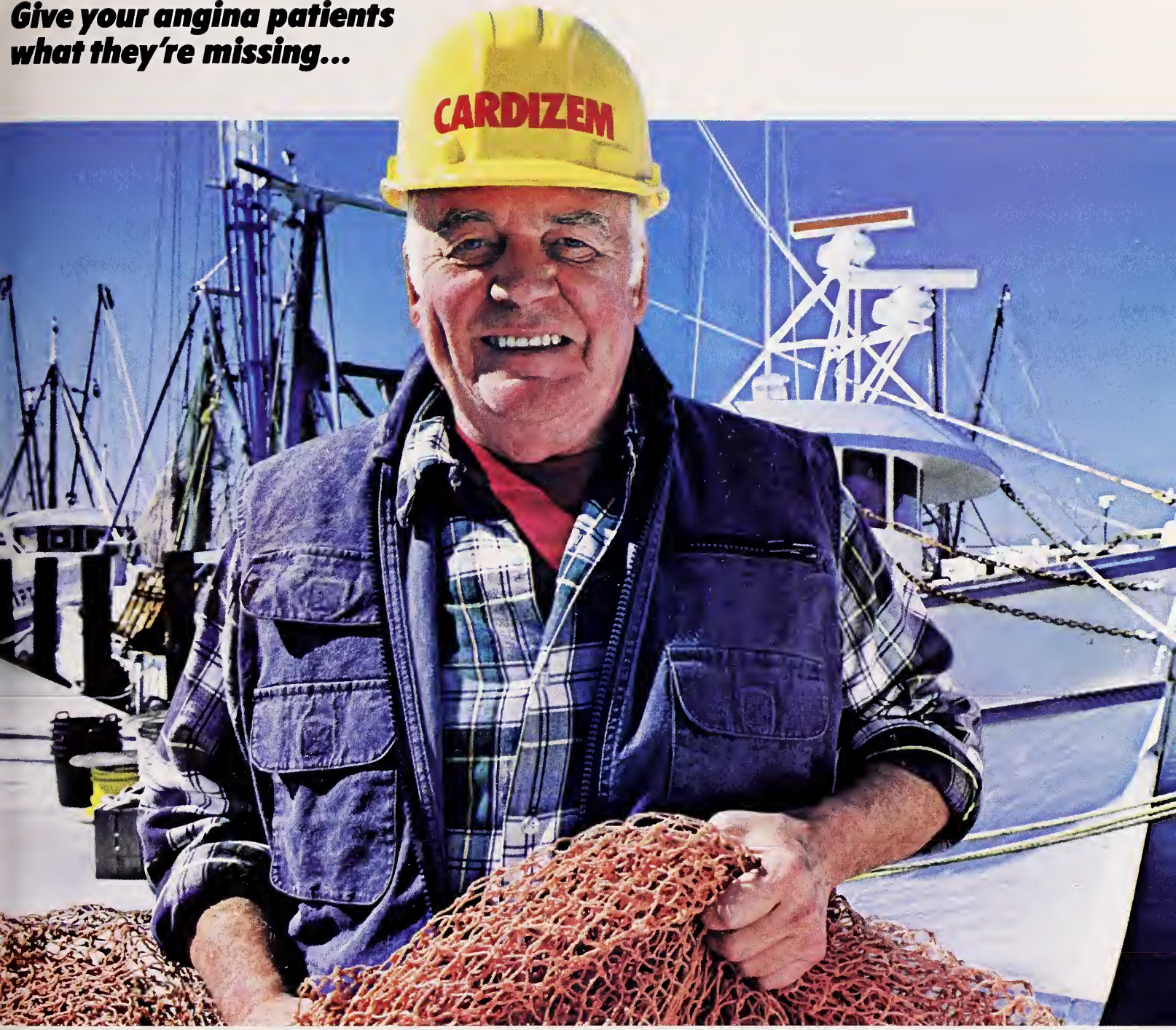


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**WARNINGS**

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

**PRECAUTIONS**

**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

**Drug Interaction.** Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

**Pediatric Use.** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS**

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

| | |
|---|---|
| Cardiovascular: | Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope. |
| Nervous System: | Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor. |
| Gastrointestinal: | Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase. |
| Dermatologic: | Petechiae, pruritus, photosensitivity, urticaria. |
| Other: | Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties. |

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

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# ADVERTISING INDEX


American Cancer Society ..... 511, 526

American Lung Association ..... 517, 530

Atlanta Magnetic Imaging ..... 481

Ayerst Laboratories ..... 482A-D

Blue Cross/Blue Shield ..... 490

Classified Ads ..... 531

Clinical Opportunity for Smoking Intervention ..... 513

Curtis 1000 Information Systems ..... 482

Family Practice Recertification ..... 481

Health Quip, Inc. ..... 518

Lilly, Eli & Company ..... 514B

MAG Mutual Insurance Company ..... 480

Marion Laboratories, Inc. ..... 530A-B

Roche Laboratories ..... 518-519, 533-534

University of Alabama Medical Center ..... 490A-B, 491

Upjohn Company ..... 514A

U.S. Air Force ..... 530

U.S. Army ..... 488

U.S. Savings Bonds ..... 526

Weight Watchers of Greater Atlanta ..... 518

Woodridge Hospital ..... 502


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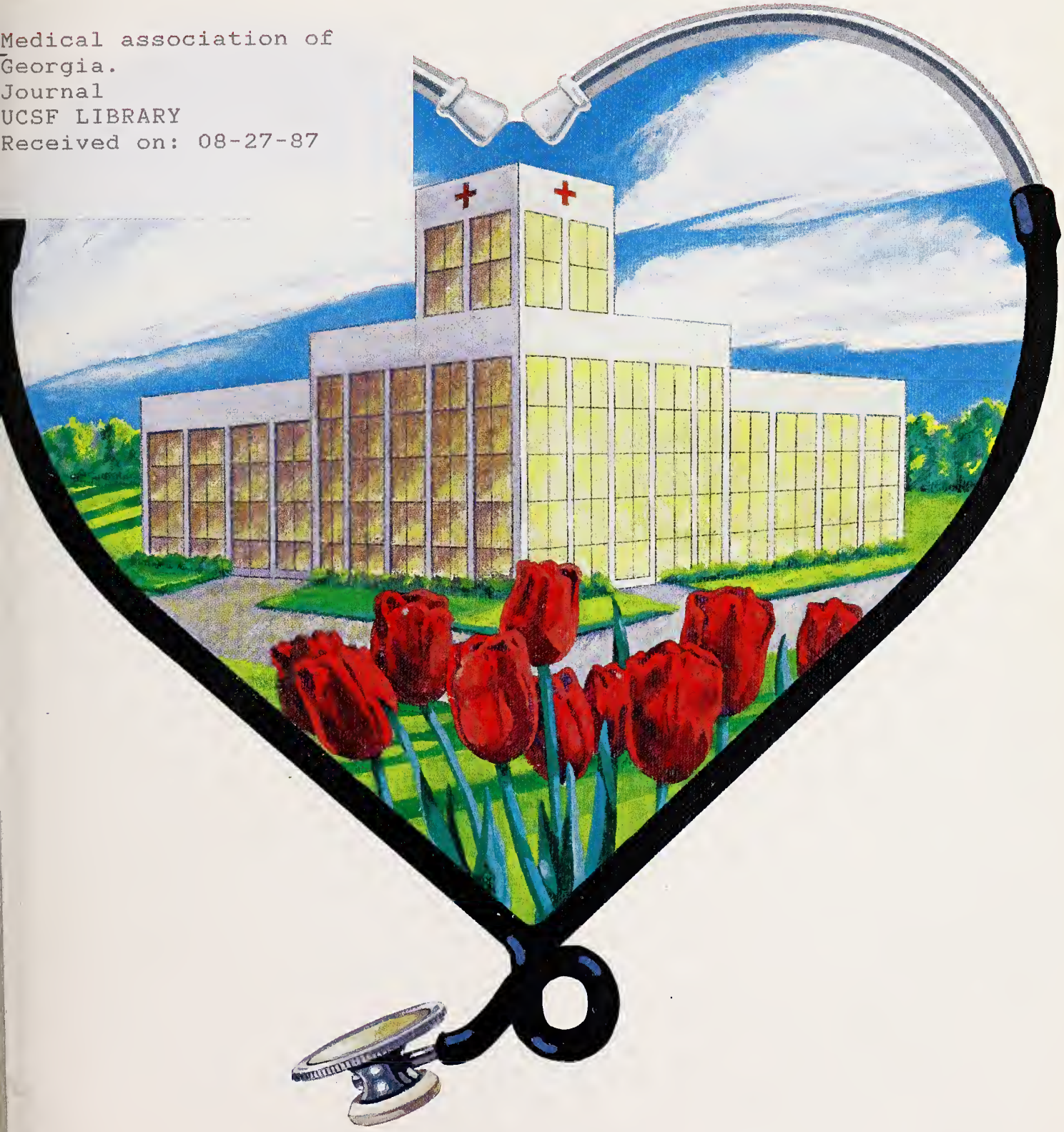

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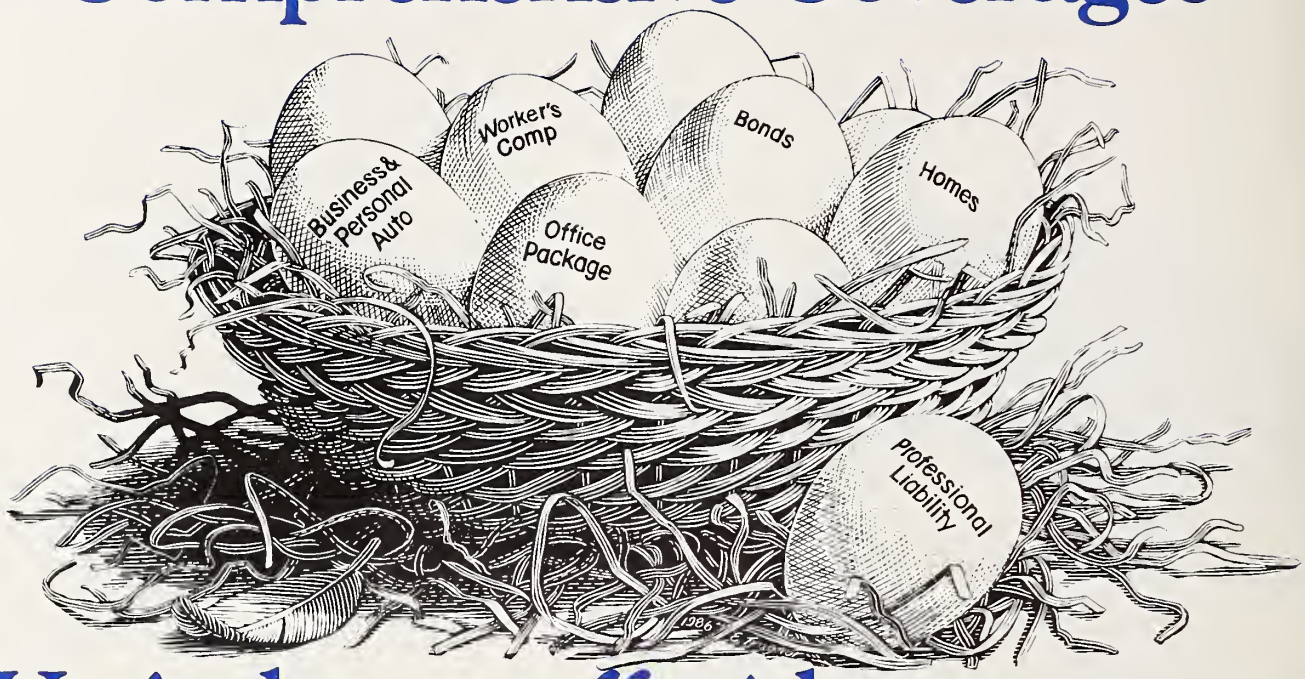


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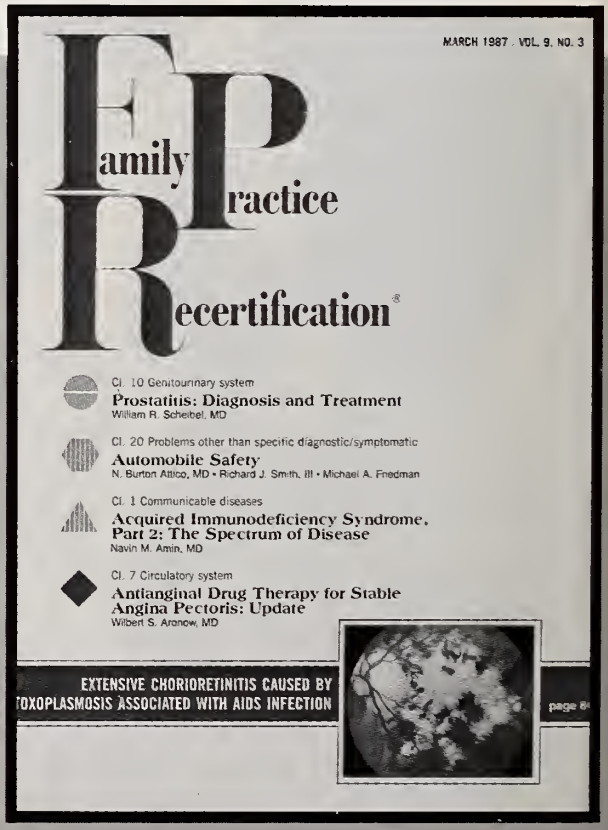


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# CONTENTS

**VOLUME 76, NUMBER 8**

## FEATURES

OVERVIEW OF A HOSPITAL 547
By Charles L. Foster, Jr.

HOSPITAL-PHYSICIAN RELATIONS: ARE WE HEADED FOR A DIVORCE? 553
By Jack Spalding Schroder, Jr.

THE YEAR 2000: A LOOK INTO THE FUTURE OF HOSPITALS AND MEDICAL STAFFS 556
By W. Daniel Barker

THE CHALLENGE OF A NEW FINANCIAL PERSPECTIVE — How It Affects The Hospital/Physician Relationship 561
By Glenn J. Black

THE GEORGIA HOSPITAL ASSOCIATION — What It Is, What It Does 566
By Max L. Brabson, Joseph A. Parker

A CONCEPT IN SEARCH OF FULFILLMENT How and Why the Joint Commission on Accreditation of Hospitals Was Formed and What It Hopes To Accomplish 569
By Dennis S. O'Leary, M.D.

PRO GEORGIA 1987 573
By Luther M. Thomas, Jr., M.D.

REFLECTIONS OF TOMORROW or The Night of the Catcus By Doctor Charlie and Ray 576
By Jim Lowry

## EDITOR'S CORNER

"WONDERLAND" — THE WAY IT WAS 540
By Charles R. Underwood, M.D.

## LEGAL

THE PRO WANTS YOU! 578
By Richard Greene

## HEART

ABSTRACTS FROM SYMPOSIUM ON CARDIOVASCULAR RESEARCH: PART II 582

## CANCER

INCIDENCE OF MELANOMA 586
By Wong-Ho Chow, Ph.D., Jonathan M. Liff, Ph.D., Raymond S. Greenberg, M.D., Ph.D.

## DEPARTMENTS

PRESIDENT'S PAGE 542

ASSOCIATION NEWS 543

CALENDAR 544

AMERICAN HOSPITAL ASSOCIATION RECOMMENDATIONS ON AIDS MANAGEMENT 545

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION ADVISORY COMMITTEE ON INFECTIONS WITHIN HOSPITALS 546

INDEX TO ADVERTISING/MANUSCRIPT INFORMATION 592

## COVER

Artwork by Pat Magers, of Decatur.

# "Wonderland" — The Way It Was

> ***"You will find the results of our efforts in this special issue of the* Journal, *in articles written by representatives of hospitals — administrators, financial people, and, forgive us, even a lawyer."***

PERHAPS THERE ARE FEW AREAS in the ordinary, and even the unordinary, physicians' lives that have changed more over the last several years than their relationship with hospitals. One would have to look far to find any one facet of physicians' lives that has required more radical and far reaching changes of them than has that essential relationship. As I have walked the halls of my hospital over the past several years, I have noticed an ever more stringent requirement that we understand and deal more harmoniously with these institutions — that an ever threatening and more widening gulf would await us should such a cooperative atmosphere not at least be sought. One did not have to look far to hear physicians discussing why the hospital had elected to start a PPO, to build a free standing ambulatory surgery center, or, Heaven help us, to deposit "satellite" clinics encroaching upon the "service area" of their practices and that of other hospitals. Nor could those same physicians sit in almost any hospital board of trustees meetings and fail to hear the acrimonious talk to the effect that if the physicians only understood the regulatory and financial strictures within the bounds of which they must operate, the entire institution would run more smoothly.

It was then that your Editorial Board thought it well to look into this matter of hospital/physician relations. You will find the results of our efforts in this special issue of the *Journal,* in articles written by representatives of hospitals — administrators, financial people, and, forgive us, even a lawyer. These individuals were asked to put their thoughts down honestly and candidly, with an intent to inform, with no purposeful effort to incite c anger, but with a clear view toward exploring the common problems which confront us. It was our hope that by so doing we could all walk with some semblance of cooperation into an unknown and exciting future instead of backing reluctantly into i

As physicians we simply must st thinking about yesterday, about the way medicine used to be practiced, and begin to spend more time accepting the present as it is. Only then can we function as a positive influence on the future. It seems tha sometimes we forget, and may I cautiously add that some of our hospital administrators do, too, that the matter of delivering health care a cooperative one. It is not possible to deliver quality health care with only one of the necessary participan functioning, any more than the engine of a car is of any use withou the wheels. We can dream of the freedom of yesterday, of fee for service in the "never, neverland" without PPOs or HMOs or PROs. But that world of yesterday is gone, it is a "wonderland."

*"At this the whole pack rose up to the air, and came flying down on her: she gave a little scream, alf of fright and half of anger, and ied to beat them off, and found rself lying on the bank, with her ad in the lap of her sister, who as gently brushing away some dead aves that had fluttered down from e trees upon her face.*

*"'Wake up, Alice dear!' said her ster. 'Why, what a long sleep u've had!'*

*"'Oh, I've had such a curious eam!' said Alice, and she told her ster, as well as she could remember em, all these strange Adventures of rs that you have just been reading out; and when she had finished, r sister kissed her, and said, 'It AS a curious dream, dear, rtainly: but now run in to your tea; s getting late.' So Alice got up and n off, thinking while she ran, as ell she might, what a wonderful eam it had been."*

When Lewis Carroll wrote those lines in 1907 and one of the ost famous of British illustrators, thur Rackham, created those quisite drawings of Alice, the hite Rabbit, the March Hare, and e Mad Hatter, etc., little could they ow that *Alice's Adventures in onderland* would become the assic it has. Carroll gave us a view a dream world one could hardly bricate in a rational state of mind.

He told us also, however, that the dream must end and the world of reality engaged in once again.

The world of medicine in the past was surely not a dream or fantasy at the bottom of a long and deep "rabbit hole" as was that of Alice. It was a real and genuine world that many of us lived and practiced in. But, our world of today, and of our tomorrows, must be faced by all of us with practical reality. To hope that we can continue practicing medicine tomorrow as we did yesterday, particularly in our relationship with hospitals, is but to live in a "wonderland," out of touch with reality. We cannot expect to practice medicine in the future as was once done in the past. Surely the basic values, the unrefutable scientific progress, must continue unfettered into the future. But, we are also living in a world of permanent change, and we must deal with that as well.

You may not agree with everything that is written in this special issue of your *Journal*. Do not be discouraged. The opinions expressed here are those of our colleagues. They, too, must exist in that world of tomorrow of which we and they are an indispensable part. They *must* deal with us and we with them. The true and honest aim of their articles is to inform and to be helpful.

*Charles R. Underwood, M.D.*

# AMA Annual Meeting

*Jack F. Menendez, M.D.*

THE 1987 AMA ANNUAL MEETING was held June 19th thru the 26th at the Chicago Hilton. We arrived Friday afternoon and immediately went to the Organization of Medical Association Presidents (OSMAP) meeting. OSMAP members include all the Medical Association President-Elects, Presidents, and Past Presidents. At the afternoon meeting, issues to come before the AMA are discussed from many different viewpoints. Friday evening, OSMAP hosts a banquet, which is a time for fellowship, making new friends, and renewing old ones.

Saturday, the meeting started in earnest with a lunch meeting of our MAG delegation, followed by an AMA briefing in the afternoon. Sunday, the annual meeting was formally opened, the awards given out, much in the same manner as our MAG Annual Session.

Monday morning started with an *early* delegation breakfast, followed by Reference Committee hearings. I was assigned to E, the committee that considered the AIDS question. It drew a large audience and received testimony from physicians throughout the country. The AIDS question took over half the day. Monday evening we had dinner with our Auxiliary AMA delegation. It was, again, a time of fellowship and discussion of the issues.

Tuesday, our delegation met for early breakfast, then went to the House to hear the floor discussion o the AIDS question. The discussants included such notables as our own Rep. J. Roy Rowland; the Surgeon General of the United States, C. Everett Koop; and others.

Wednesday and Thursday, the House finished the Reference Committee reports. Much important work was done, setting guidelines fo policy for many health care issues.

Thursday afternoon, the meeting adjourned, the delegates return to their practices, etc. The "day" for the delegates was very long and grueling. It usually started with a delegation breakfast at 6:30 a.m. followed by either reference committee hearings or floor discussions ending around 5:00 p.m. The evenings were usually enjoyable with parties for candidates featuring regional food, such as, Texas Chili (no beans), California Guacamole, Venison Sausages at the Rocky Mountain coalition, North Carolina Barbecue, and much, much more. We went from party to party, gathering election paraphernalia, more than we could carry or wear.

Wednesday evening, our new AMA President, Dr. William L. Hotchkiss, from Virginia, was installed in a very impressive ceremony. I feel the AMA will be in good hands the coming year.

Jack F. Menendez

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## QUOTES

*Praise is the best diet for us, after all.*
SYDNEY SMITH

*An ounce of performance is worth more than a pound of preachment.*
ELBERT HUBBARD

*Faith is believing that something will be, or is!*
STEPHEN KING

*When the fight begins within himself, a man's worth something.*
ROBERT BROWNING

*Nothing has an uglier look to us than reason, when it is not on our side.*
GEORGE SAVILE

*Censure is often useful, praise is often deceitful.*
WINSTON CHURCHILL

*Life offers itself equally to the small and the great, the weak and the strong.*
ALEXIS CARREL

*When put to the test, an ounce of loyalty is worth a pound of cleverness.*
ELBERT HUBBARD

*Preposterous ass, that never read so far to know the cause of why music was ordained; was it not to refresh the mind of man after his studies or his usual pain?*
SHAKESPEARE

*If you want enemies, excel others; if you want friends, let others excel you.*
CALEB C. COLTON

*Little drops of water wear down big stones.*
RUSSIAN PROVERB

*Success is not searching for you. You must do the seeking.*
FRANK TYGER

*Things were good once, and they'll be good again; the only trouble with the world is that it's right now.*
JACK WEBB

*He who has no inclination to learn more will be very apt to think that he knows enough.*
THOMAS POWELL

## SEPTEMBER

4-6 — *Sea Island:* **Georgia Gastroenterologic Society.** Category 1 credit. Contact Steve Morris, M.D., 25 Prescott St., Atlanta. PH:404/881-1094.

4-6 — *Sea Island:* **Ga. Society of Internal Med. & Ga. Chapter, Amer. Coll. of Phys. Joint Meeting.** Category 1 credit. Contact Milton Frank, M.D., GSIM, 1372 Peachtree St., N.E., Ste. 301, Atlanta 30309. PH:404/892-2131 or Mark Silverman, M.D., Ga. Chapt., ACP, 1968 Peachtree Rd., Atlanta 30309. PH:404/350-3368.

15 — *Columbus:* **1987 Infectious Disease Update.** Category 1 credit. Contact Mrs. Judy Anderson, Internal Medicine Found., P.O. Box 311, Columbus 31902-0311. PH:404/571-1454.

17-19 — *Hilton Head Island, SC:* **9th Annual Frontiers in Nutrition.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

17-19 — *Sea Island:* **Georgia Surgical Society Annual Meeting.** Category 1 credit. Contact William C. McGarity, M.D., Secy.-Treas., GSS, Dept. of Surgery, 1365 Clifton Rd., Atlanta 30322. PH:404/321-0111.

20-23 — *Hilton Head Island, SC:* **Georgia Obstetrical and Gynecological Society, Inc.** Contact Chester Lane, Execu. Dir., 69 Butler St., Atlanta 30303. PH:404/659-0289.

28-Oct. 2 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

30-Oct. 2 — *Savannah:* **11th Annual Neonatology — The Sick Newborn.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

## OCTOBER

1-4 — *Sea Island:* **Georgia Orthopaedic Society Annual Meeting.** Category 1 credit. Contact David F. Apple, Jr., M.D., Secy., GOS, 1938 Peachtree Rd., Ste. 710, Atlanta 30309. PH:404/352-2234.

5-10 — *Augusta:* **Obstetrics and Gynecology.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

6 — *Columbus:* **7th Annual Day of Endocrinology.** Category 1 credit. Contact Mrs. Judy Anderson, Internal Medicine Foundation, P.O. Box 311, Columbus 31902-0311. PH:404/571-1454.

8-9 — *Atlanta:* **Georgia Chapter, American Academy of Pediatrics Fall Meeting.** Category 1 credit. Contact William C. Mankin, Exec. Secy., Ga. Chapter, AAP, 4059 Land O'Lakes Dr., Atlanta 30342. PH:404/237-3922.

9 — *Atlanta:* **Practical Management of Psychiatric Disorders.** Category 1 credit. Contact Emory Univ. Sch. of Med., Dept. of Psych., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

9-11 — *Atlanta:* **New Trends in Office Gastroenterology.** Category 1 and AAFP prescribed credit. Contact Div. of CME, MCG, Augusta 30912-6450. PH:404/828-3967.

10 — *Atlanta:* **Cardiology Symposium.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

10-14 — *Atlanta:* **American Society of Anesthesiologists.** Category 1 credit. Contact AASA, 515 Busse Highway, Park Ridge, IL 60068. PH:312/825-5586.

12-15 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:4 727-5695.

13-16 — *Atlanta:* **American Soci of Internal Medicine.** Category 1 credit. Contact Teresa Crumpler, ASIM, 1101 Vermont Ave., Ste. 500, Washington, DC 20005. PH:202/289-1700.

14 — *Atlanta:* **9th Annual Josepl S. Skobba Symposium.** Category credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:4 727-5695.

19-20 — *Atlanta:* **Quantitative Thallium Myocardial Tomograp** Category 1 credit. Contact Office CME, Emory Univ. Sch. of Med. 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

21-23 — *Atlanta:* **What's New in Magnetic Resonance Imaging?** Category 1 credit. Contact Office CME, Emory Univ. Sch. of Med. 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

22-24 — *Atlanta:* **Alternatives to Cutaneous Urinary Diversion.** Category 1 credit. Contact Amer. Urological Assn. Ofc. of Educ., 6750 W. Loop South, Ste. 900, Bellaire, TX 77401. PH:713/665-7500.

26-30 — *Atlanta:* **American Colle of Chest Physicians.** Category 1 credit. Contact ACCP, 911 Busse Highway, Park Ridge, IL 30068. PH:312/698-2200.

29-30 — *Atlanta:* **Health Care: A Basic Human Need.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:40 727-5695.

Depressed and anxious,
she's sitting out life
instead of living it

# From "looking"...

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Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) (IV)

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**References: 1.** Feighner JP, *et al:* Psychopharmacology 61:217-225, Mar 22, 1979. **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Dixon R, Cohen J: J Clin Psychopharmacol 3:107-109, Apr 1983.


**Limbitrol® (IV)**
**Tranquilizer—Antidepressant**
**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of moderate to severe depression associated with moderate to severe anxiety.

**Contraindications:** Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

**Warnings:** Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

**Precautions:** Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

**Adverse Reactions:** Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and blacking. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

*Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmia, heart block, stroke.

*Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

*Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

*Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

*Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

*Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

*Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

*Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

*Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

**Overdosage:** Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

**Dosage:** Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

**How Supplied:** *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). Available in bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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P.I. O

## American Hospital Association

# Recommendations on AIDS Management

*Carol M. McCarthy, Ph.D., J.D.*

On May 22, 1987, the Centers for Disease Control released case studies of three health care workers who contracted the AIDS virus through exposure to large amounts of infected blood. This announcement came at a time when both health care workers and their employers are growing increasingly concerned about protection of workers from AIDS virus infection.

In response to this concern the AHA Advisory Committee on Infections within Hospitals met to reevaluate their recommendation on the management of AIDS in the hospital. After examining several options, the committee issued a statement urging all hospitals to treat all patients' blood and body fluids as hazardous. The statement further recommends against mandatory or routine testing of patients as a means of protecting the employee. We urge your support of this statement (enclosed) for several reasons:

- It provides protection against a broad range of blood borne diseases. Although the current concern is AIDS, there are several other blood borne diseases which may be occupationally transmitted, primarily hepatitis B and increasingly, hepatitis non A-non B.
- Because of the protection against a variety of diseases, this recommendation is appropriate for *all* hospitals in *all* geographic locations even if all hospitals have not yet treated patients with AIDS.
- The U.S. Occupational Safety and Health Administration (OSHA) is considering issuing regulations which would mandate the use of the protections we are urging. A strong voluntary effort on our part may well convince OSHA that such regulation is unnecessary. A weak effort will effect the reverse.
- Unlike routine testing of hospital patients, this approach provides the best protection of employees without compromising patient care and confidentiality.
- Although the implementation of this recommendation may increase the cost of supplies, the costs of follow-up testing of employees following exposure and the costs of hospital admission testing are considerably higher.

In brief, while this recommendation may create some initial financial stress and require a large investment of staff time in education, training, and monitoring compliance, we believe this is the most cost-effective approach to protecting the health of employees and maintaining the highest standards of patient care.

To help you, our members, implement these recommendations we will present a special BULLETIN via satellite on August 12, 1987, addressing the recommendations on universal precautions. Faculty will include professionals from hospitals following universal precautions for over a year who will share successful strategies with you. The BULLETIN will be broadcast to all AHA member hospitals and tapes of the broadcast made available to member hospitals that do not have satellite facilities *free of charge*. In addition, because of the importance of AIDS precautions, a video tape dealing with proper specimen handling and ER and OR procedures is being developed and will be available in late August.

The management of AIDS is a challenge for all hospitals — as employers of health care workers at risk, as providers of care to those afflicted, and as leaders in community education. The Association is currently working doubletime to develop educational services wherein those hospitals with significant experience in treating AIDS patients can share the lessons learned from their efforts. In October, an AHA teleconference will fully explore the financing, treatment, and delivery mechanisms that are needed to meet the challenge of caring for AIDS patients. We will also be developing new materials on community education on the AIDS issue.

Much more detailed information on AHA resources to help hospitals address the AIDS issue will be available at the AHA convention. A special section of the AHA Resource Center will be staffed to answer specific AIDS-related questions. In addition, a portion of AHA's live teleconference broadcast from the convention will be devoted to the management of AIDS.

In the meantime, if you have questions regarding any aspect of AHA's activities on AIDS, please contact Linda Brooks, AIDS program coordinator, at 312/280-6130. ■

Dr. McCarthy is President of the American Hospital Association.

Statement of the

# AHA Advisory Committee on Infections Within Hospitals:

# PROTECTION OF HEALTH CARE WORKERS

The Advisory Committee on Infections Within Hospitals of the American Hospital Association (AHA) has reviewed the recent Centers for Disease Control (CDC) update concerning infection with the Human Immunodeficiency Virus (HIV) in three health care workers exposed to blood of infected patients. During this review, discussions were held with representatives of the CDC. The CDC update (MMWR 5/22/87, Vol. 36, No. 19) noted that ". . . the precise risk of transmission during exposures of open wounds or mucous membranes to contaminated blood cannot be defined, . . . studies indicate that it must be very low." The committee nonetheless concurs with CDC and recommends, THAT FOR EVERY HOSPITAL, PRECAUTIONS MUST BE STRICTLY FOLLOWED WHENEVER THERE IS A POSSIBILITY OF EXPOSURE TO BLOOD OR OTHER BODY FLUIDS. ALL ANTICIPATED EXPOSURE REQUIRES THE USE OF GLOVES. SOME KINDS OF EXPOSURES MAY ALSO REQUIRE THE USE OF GOWNS, MASKS, AND EYE COVERINGS. HANDS AND OTHER CONTAMINATED SKIN SURFACES SHOULD BE WASHED THOROUGHLY AND IMMEDIATELY IF ACCIDENTALLY CONTAMINATED WITH BLOOD OR BODY FLUIDS.

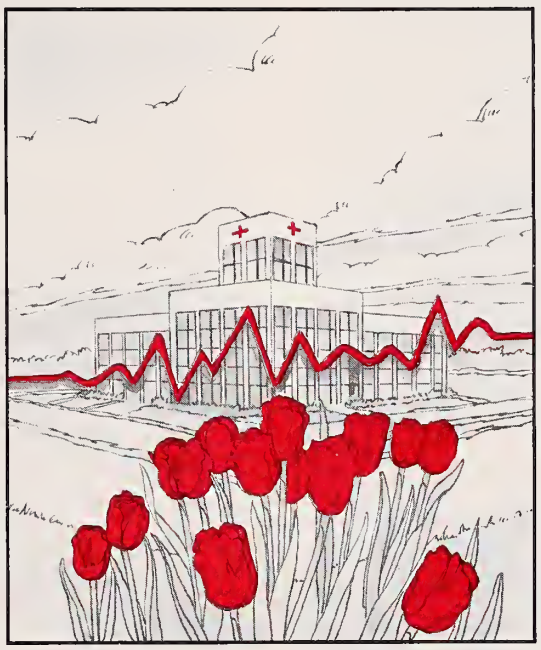
It should be noted that previous AHA guidelines only recommended the use of precautions for the handling of patients or specimens infected with HIV. The committee is now recommending these precautions for ALL blood or body fluid exposure. In light of the above recommendation, some instituituions may wish to discontinue the labeling of specimens and the use of blood and body fluid precautions for individual patients, as these precautions should now be applied universally.

Institutions implementing this recommendation must assure it applies for all hospital personnel coming in contact with blood or body fluids. This can be achieved through adequate training, supervision, and the assurance the supplies and equipment are readily available to personnel.

In making this recommendation, the Advisory Committee on Infections concurs with the CDC that universal use of blood and body fluid precautions represents the best means of protection of health care personnel against HIV transmission, rather than routine HIV testing of all hospital patients. Furthermore, reliance on negative HIV test results to determine when to apply specific precautions may lead to a false sense of security and the taking of unreasonable risks. Both the Advisory Committee on Infections and the CDC continue to emphasize, however, the value of HIV serologic testing for patient diagnosis and management on a selective case-by-case basis. ■

# OVERVIEW OF A HOSPITAL

**Charles L. Foster, Jr., F.A.C.H.E.**



HOSPITAL CARE in the United States has traditionally been one of the basic services provided to the community, not unlike the services of schools, the fire department, and the police department. These services were viewed as necessary for the good of the community and until the last decade have primarily been not-for-profit, tax exempt, local institutions. During the last 2 decades, the investor-owned hospital system has emerged and proliferated. The investor-owned segment of the health care industry is a strong and viable part of the health delivery system. In essence, hospitals in the investor-owned group provide health care services with the ultimate goal of making a profit to distribute back to the investors.

Mr. Foster is Administrator, West Georgia Medical Center, P.O. Box 1567, LaGrange, GA 30240. Send reprint requests to him.

The other segment of the hospital system is the not-for-profit/hospital authority hospitals. These hospitals are for the most part community based and tax exempt. Profits, if any, are used to provide additional services. Although investor-owned hospitals are currently playing a significant role in overall health care delivery in our nation, there is much to be said for the non-profits which continue to survive and, in some cases thrive, in the current climate of DRGs and other forces at work in the industry today,

### Changes in the Industry — An Historic Perspective

The impact of the DRG, quality assurance, consumer lifestyles and changes in medical practice has affected every hospital, regardless of ownership, location, mission, or size. Yet, if one examines the history, there has been constant change in our hospital system. Before

World War II, hospitals existed only as places where extremely sick or severely injured people were kept comfortable because little could be done for them. There were no miracle drugs such as penicillin, sophisticated surgical procedures, or transplant technology. During World War II, giant steps were made in caring for the sick and injured. These phenomenal changes have had a tremendous impact on the American health care system, resulting in a healthier population with a longer life expectancy.

***"There is an old saying that there are three reasons to build a hospital under the Hill Burton program: need, greed, and community pride."***

In 1946, the Hill Burton Act was passed. This program provided Federal loans and grants for construction and renovations of hospitals throughout this country. There is an old saying that there are three reasons to build a hospital under the Hill Burton program: need, greed, and community pride. Consequently, hospitals literally developed overnight in virtually every community in the United States. The advent of the Hill Burton program required states to license hospitals, and it placed certain stipulations on hospitals to provide free care in exchange for Hill Burton funding.

In the 1960s, many thought the solution to wide and equitable distribution of health services was money and, indeed, money was essentially embodied in the amendments of 1965 to the Social Security Act which resulted in Medicare and Medicaid. These two programs set forth a mandate which in effect stated that the American taxpayer would be responsible for paying for the health care needs of the elderly and the poor, the largest consumers of health care. The much debated law when passed in essence made a simple statement: "Health care providers, take care of the health needs of the elderly and the poor, and we will pay your cost to provide this care."

Health providers at all levels, hospitals, physicians, research centers, and medical schools, set about to provide quality health care to be reimbursed at cost. The results of this action were phenomenal, technologically and economically. By Fiscal 1970, 20.4 million people 65 and older were enrolled. Costs for the programs were enormous. In 1971, $7.9 billion ($5.6 billion for hospital insurance and $2.3 billion for medical insurance) was pumped into the health care industry. During the first 4 years of Medicare/Medicaid funding, expenditures doubled. The average length of hospitalization at that time was 12.4 days.

Along with the impressive price tag of Medicare/Medicaid came an equally impressive list of accomplishments in the medical field including organ transplantation, outpatient surgery, coronary artery bypass grafting, renal dialysis, and home health which are but a few procedures that have evolved in the last 2 decades. The civil rights movement also affected the health care field in many ways. Segregation of black patients was discontinued, and black physicians became members of medical staffs of our hospitals.

Then came the Health Maintenance Organizations (HMOs), Preferred Provider Plans (PPOs), and other organizations providing comprehensive health care.

***"The evolution of our health care system has been shaped under constantly changing economic conditions, governmental regulations, and societal values."***

In the early 1980s, our federal government reexamined the Medicare program, focusing their attention on cost issues. Health providers as a result were given new instructions on taking care of the elderly. The new rule of the game was to continue providing the same or better standard of care; however, the reimbursement for this service was changed. Thus came the advent of the Diagnosis Related Grouping (DRG). Very simply, the government

stated, "we will pay the hospital providers a one-time flat fee per diagnosis for the reason the patient is admitted to the hospital." The result and current system is that hospitals receive a one-time payment for the care given based on the diagnosis, regardless of resources and/or the time it takes to provide this care. As one can easily see, the evolution of our health care system has been shaped under constantly changing economic conditions, governmental regulation, and societal values. These major forces have cast the current climate under which modern hospitals must operate today.

### Governance

The birth of a hospital results from a charter and the establishment of bylaws. These two documents are the ultimate guiding forces for hospital operation. It outlines the hospital's purpose and sets forth stipulations regarding its board of trustees, management, and medical staff. The charter also establishes the number of trustees, how they are selected, and their duties and responsibilities. Usually the trustees are charged with three primary responsibilities: 1) setting the overall policy under which the hospital will be operated; 2) appointing and outlining the responsibility of the chief executive officer to carry out their policy; and, 3) appointing the medical staff. The responsibility and authority of the board of trustees is final.

### Administrator/Chief Executive Officer

The chief executive officer, administrator/president's duties are specifically outlined in the bylaws created by the board of trustees. Simply stated, the chief executive officer is responsible for carrying out the policies of the board. These include fiscal, personnel, and all other facets of management. The administrator reports directly to the board at all times and all personnel employed by the hospital ultimately report to the administrator.

### Medical Staff

The medical staff of the hospital operates through a set of bylaws and rules and regulations. These bylaws and rules and regulations are developed by the medical staff and to be effective they must be revised and updated on a regular basis. All medical staff bylaw changes must be approved by the governing authority. The chief executive officer, as direct agent of the board of trustees, is responsible for maintaining a close working relationship with the medical staff and attends all meetings as a representative of the hospital's governing body.

Members of the medical staff are granted the privilege of admitting patients to a hospital after a thorough credentialing process. Final approval for appointment to the medical staff rests with the hospital authority. Physicians are responsible for credentialing, quality assurance, serving on various committees, and making recommendations to the governing board.

Cooperation from each of the three disciplines — the board of trustees, the administrator, and the medical staff, is essential in carrying out the hospital's mission.

### Funding Sources

Revenue or income for hospitals is generated from services rendered to patients. Generally, there are three types of payors: the patient, the government, and private insurance. The government is clearly the largest contributor of revenues to hospitals for services rendered to government-sponsored patients. It is not unusual for the Medicare and Medicaid program to supply over 60% of the revenue for many non-profit community hospitals. The remaining 40% must encompass private insurance, private pay, and the indigent. Not-for-profit hospitals are experiencing the highest indigent case load in the history of medicine which is having a tremendous negative effect on hospital revenues. The government, through its use of the DRG, and Medicaid, through a single payment source per admission, has jeopardized the hospital's ability to maintain fiscal stability.

Not-for-profit hospitals are seeking more and more financial assistance from individual contributions as well as contributions from foundations. These sources of funds have been a tremendous asset to the aggressive hospital seeking other ways of maintaining fiscal viability.

### Diversification Key to Success

Hospitals today are complex corporations that have specific mission statements and goals and objectives for the future. More and more hospitals of all types are looking at what they are doing in the health care market place and what they will be doing in the health care market place in 2, 5, and 10 years. The changing role of the hospital reflects that many are now providing home health services, renal dialysis units, free-standing cancer treatment facilities, wellness programs, durable medical equipment companies, helicopter services, long-term care facilities, and continuing care retirement communities. All of these represent critical changes from the traditional role of the hospital as simply an acute care inpatient facility. The role is broadening and deepening as hospital corporations follow a strategy of integrating all kinds of patient care under one organization — an organization with a history and a mission of quality care.

### Common Problems in Hospitals

1) *Financial* — The financial plight of hospitals has previously been described. Diversification is the common thread for the future that hospitals must address in order to generate revenues outside the DRG. It is not inconceivable that hospitals will compete with their own medical staff and the community in providing these services. Joint ventures between hospitals and their medical staff may produce outcomes advantageous to both. Not-for-profit hospitals particularly must be well advised by counsel regarding loss of favorable tax status as these diversification strategies are implemented.
2) *Personnel* — Hospitals are considered labor intensive organizations and require diversified specialists to provide quality patient care. A critical shortage of some professionals exists, i.e. registered nurses, medical technologists, pharmacists, physical therapists, and others. Price wars between hospitals to recruit these people is not the solution to the problem. Hospitals of all types must develop strategies to maintain an adequate supply of quality health care professionals.

   Hospitals must also develop their own internal mechanism to retain employees by providing a good working environment, competitive salaries, and strategies for job satisfaction.
3) *Physicians* — The medical staff of a hospital is a significant and integral part of the success and viability of a hospital. Only physicians can admit and discharge patients. Consequently, the success of the hospital rests with the individual members of the medical staff. Therefore, it is critical that open lines of communication and cooperation must exist between the board of trustees, hospital management, and the medical staff. As more and more pressures are being placed on physicians by the PRO, the DRG, and other forces, the barriers caused by these activities produce conflicts that must be resolved.

   Physicians and hospitals have also been burdened with many malpractice cases filed against them and occasionally large awards are made. In many cases, this has caused physicians and hospitals to practice more "defensive medicine" which is frustrating, agonizing, and very expensive to consumers.

***"The role (of hospitals) is broadening and deepening as hospital corporations follow a strategy of integrating all kinds of patient care under one organization — an organization with a history and a mission of quality care."***

State licensing boards have traditionally granted licenses to physicians after a check of their background and education. More and more state licensing boards are requiring hospitals to report to them actions taken with respect to a physician's medical staff appointment and clinical privileges. The federal government passed the Health Care Quality Improvement Act of 1986 also requiring reports on quality and

competence of physicians on the medical staff.

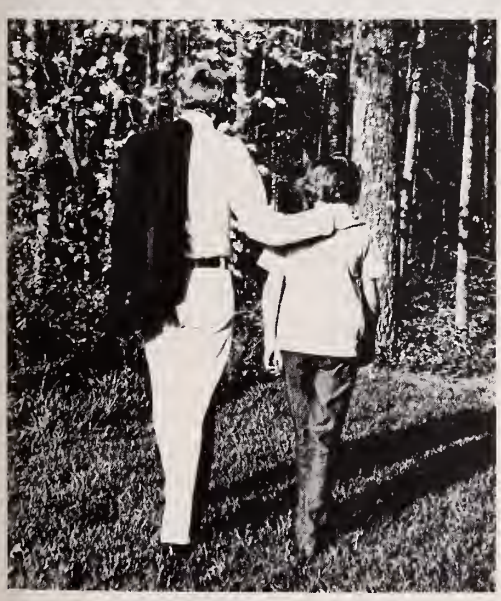
### Summary

Hospitals throughout the nation represent a complex, complicated organization that deal with life and death. The key ingredients of a successful hospital are the cooperation, understanding, and communication between the board of trustees, the management team, and the medical staff. The success of the hospital of the future weighs heavily with these three groups. Hospital boards of directors should have physicians as voting members of the board. These physicians should wear their governance hat and not be "representatives of the medical staff." In order to cope with the future, the board of trustees must develop a strategic long-range plan to insure viability of their organization. After all, if the hospital fails, the physicians have the largest stake and would be the biggest loser.

***"Not-for-profit hospitals are experiencing the highest indigent case load in the history of medicine which is having a tremendous negative effect on hospital revenues."***

It is essential that cooperation at all levels must exist. Hospitals must effectively compete to provide the health care services that are needed to serve the population of their institutions. The hospital of the future will be challenged with different opportunities, and it must strategically place itself in the market place to address issues as they develop. No one entity, i.e., board, management, medical staff, can assume this responsibility. It takes all three disciplines working in harmony. ■


# At CPC Parkwood, Caring Comes First



CPC Parkwood Hospital is a private, comprehensive psychiatric and chemical dependency treatment facility designed and staffed to meet the individual needs of patients through the following specialized programs and services:

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- Adolescent Psychiatric Program
- Child Psychiatric Program
- Adult Alcohol & Drug Program
- Adolescent Alcohol & Drug Program
- Eating Disorders Program
- 24-Hour Psychiatric Assessment Team

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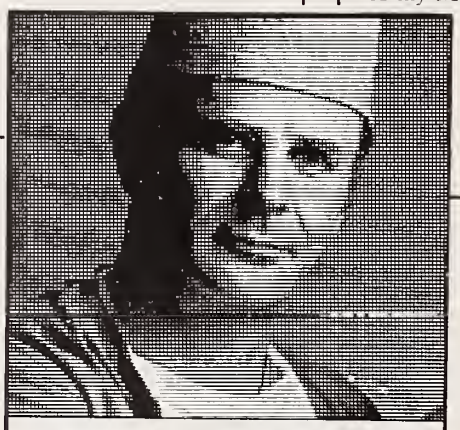

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**WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

**Contraindications:** Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings:** **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum $K^+$ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict $K^+$ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

**Precautions:** The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

**Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.**

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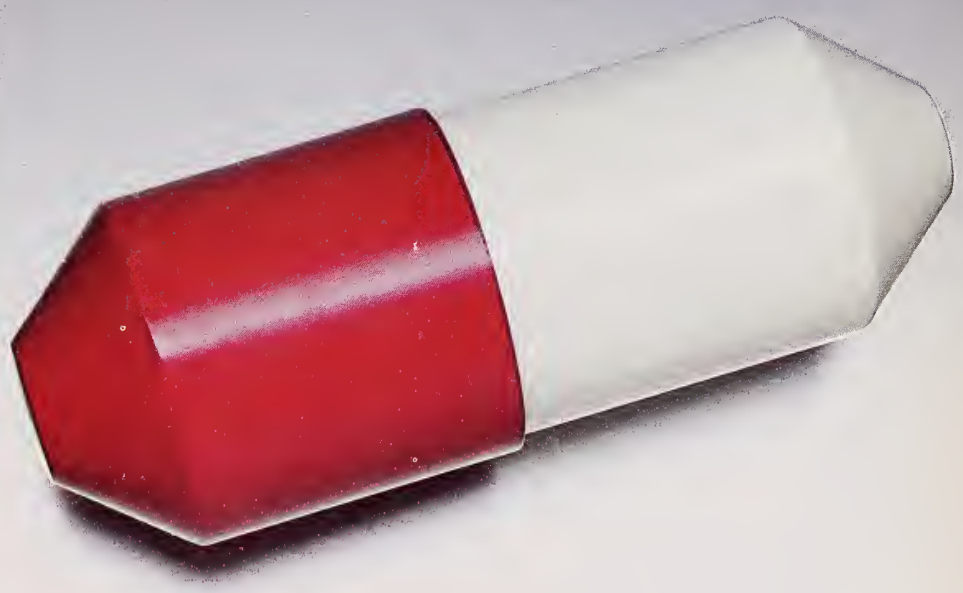

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**Percent of patients ulcer-free after 1 year of therapy**

| | |
|---|---|
| **ZANTAC** 150 mg h.s. (n = 60) | 84%* |
| **cimetidine** 400 mg h.s. (n = 66) | 57% |
| **ZANTAC** 150 mg h.s. (n = 243) | 77%† |
| **cimetidine** 400 mg h.s. (n = 241) | 63% |

*P = 0.01 †P = 0.0004 % life-table estimates

All patients were permitted prn antacids for relief of pain.
Adapted from Silvis[1] and Gough[2]

These two trials[1,2] used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comparison of other dosing regimens has not been studied.
The studied dosing regimens are not equivalent with respect to the degree and duration of acid suppression or suppression of nocturnal acid.
The superiority of ranitidine over cimetidine in these trials indicates that the dosing regimen currently recommended for cimetidine is less likely to be as successful in maintenance therapy.

**Zantac® 150 h.s.**
*ranitidine HCl/Glaxo 150 mg tablets*

Glaxo / ROCHE®

See next page for references and Brief Summary of Product Information.

ZAN375 July 1987

**References: 1.** Silvis SE, Griffin J, Hardin R, et al: Final report on the United States multicenter trial comparing ranitidine to cimetidine as maintenance therapy following healing of duodenal ulcer. *J Clin Gastroenterol* 1985;7(6):482-487.
**2.** Gough KR, Korman MG, Bardhan KD, et al: Ranitidine and cimetidine in prevention of duodenal ulcer relapse: A double-blind, randomised, multicentre, comparative trial. *Lancet* 1984;ii:659-662.

**ZANTAC® 150 Tablets**
**(ranitidine hydrochloride)**
**ZANTAC® 300 Tablets**
**(ranitidine hydrochloride)**

**BRIEF SUMMARY OF PRODUCT INFORMATION**

The following is a brief summary only. Before prescribing, see complete prescribing information in ZANTAC® product labeling.

**INDICATIONS AND USAGE:** ZANTAC® is indicated in:
1. Short-term treatment of **active duodenal ulcer.** Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within one or two weeks after starting therapy and is maintained throughout a six-week course of therapy.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

**CONTRAINDICATIONS:** ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

**PRECAUTIONS:** Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy.

Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSAGE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Although recommended doses of ZANTAC do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Lack of experience to date precludes recommending ZANTAC for use in children or pregnant patients. Since ZANTAC is secreted in human milk, caution should be exercised when administered to a nursing mother.

**ADVERSE REACTIONS:** Headache, sometimes severe, seems to be related to ZANTAC® administration. Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

There have been rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

**OVERDOSAGE:** Information concerning possible overdosage and its treatment appears in the full prescribing information.

**DOSAGE AND ADMINISTRATION: Active Duodenal Ulcer:** The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

**Maintenance Therapy:** The current recommended adult oral dosage is 150 mg at bedtime.

**Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome):** The current recommended adult oral dosage is 150 mg twice a day. In some patients it may be necessary to administer ZANTAC 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

**Benign Gastric Ulcer:** The current recommended adult oral dosage is 150 mg twice a day.

**GERD:** The current recommended adult oral dosage is 150 mg twice a day.

**Dosage Adjustment for Patients with Impaired Renal Function:** On the basis of experience with a group of subjects with severely impaired renal function treated with ZANTAC, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

**HOW SUPPLIED:** ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

**Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.**

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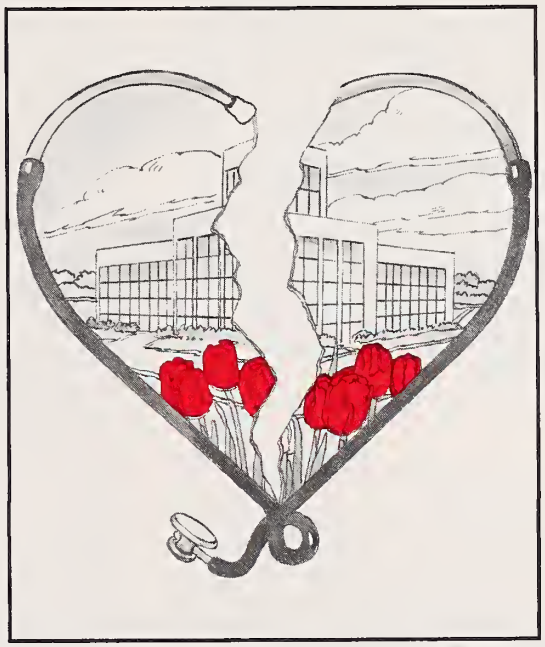
# Hospital-Physician Relations: Are We Headed For A Divorce?



**Jack Spalding Schroder, Jr.**

HOSPITALS OFTEN MAKE decisions which, from the physician's perspective, appear to intrude into their traditional physician-patient relationship. One need only consider recent trends by hospitals to establish joint ventures and HMOs — programs which 5 years ago were considered the exclusive domain of physicians, private investors, and insurers. Increasingly, hospitals have taken the lead role in these efforts, and physicians feel they are losing control over the fees they may charge and the procedures they may perform. As a result, physicians feel alienated from the hospital policy-making process. Add to these anxieties the compounding forces of skyrocketing malpractice premiums and increased governmental intervention, and you have the perfect formula for disruputive hospital-physician relations.

Since lawyers are blamed (occasionally with justification) for exacerbating society's problems, lawyers must surely share some of the blame for the growing discord between hospitals and physicians. Oftentimes, while attempting to protect their clients from legal pitfalls, lawyers fail to adequately communicate the reasons for their advice. Consequently, what may be viewed by the lawyer as legal expedience may be viewed by the physician as an unwarranted invasion into his or her historic turf. While this writer can offer no panacea for these ills, it is hoped that this article will at least provide the physician with some insight into the hospital's legal perspective on several areas of increasing conflict.

Perhaps an example can best illustrate how conflicts often arise between the legal and medical disciplines. A rural hospital with a desperate need for obstetric services receives an application for medical staff privileges from a young board-certified obstetrician. During the credentialing process, objections to the application are voiced by Dr. Birthright, a family practitioner who happens to be the only physician in the community currently delivering babies. Dr. Birthright's concerns are vague and non-specific but, being current Chairman of the Credentials Committee, his voice carries great weight. The administrator, faced with the possible rejection of his prize recruit, turns to hospital counsel for guidance. On the basis of legal advice, the hospital administrator asks Dr. Birthright to excuse himself from any Credentials Committee deliberations concerning the new applicant, thereby depriving the Committee of input from the only

Mr. Schroder is a partner in the law firm of Alston & Bird, 100 Galleria Parkway, Ste. 1200, Atlanta, GA 30339.

staff member knowledgeable about obstetrical qualifications and experience. Dr. Birthright is incensed, the medical staff is baffled, and the hospital administrator has a major controversy on his hands.

***It is hoped that this article will . . . provide the physician with some insight into the hospital's legal perspective on several areas of increasing conflict.***

As it turns out, the lawyer was actually trying to protect both the hospital and Dr. Birthright from antitrust liability. Since Dr. Birthright offered no specific factual basis for his "concerns" about the obstetrician, the lawyer suspected his actions were based more on economic self-interest than quality of care. The lawyer was also aware of a new federal law, the Health Care Quality Improvement Act of 1986,[1] which immunizes peer review participants from liability provided applicants are reviewed by individuals "not in direct economic competition with the physician involved."[2] Since the applicant's file included glowing references from well-regarded obstetricians in other communities, the attorney concluded the loss of Dr. Birthright's obstetric expertise was well worth the price of avoiding an antitrust suit.

Although the antitrust laws were only deemed applicable to the health care industry in the last decade, they have become a pervasive influence in day-to-day hospital operations. For example, when a PPO is being formed in a community, the obvious inclination is to recruit as many physicians as possible to be participating providers. Once again, what appears to be a solid business tactic does not always constitute sound legal strategy. The Antitrust Division of the Department of Justice has previously stated that the membership of a provider-sponsored PPO must not be so inclusive as to prevent the formation of effectively competing PPOs.[3] Thus, any hospital wishing to sponsor a PPO must avoid including too large a percentage of a community's physicians lest it incur the wrath of the federal government. Unfortunately, this often results in hard feelings among those physicians who are excluded from participation in the PPO, and who never realize their exclusion was based upon antitrust concerns rather than competence, personality, or some other non-legal basis.

In addition to antitrust and other legal restrictions imposed on all industries, the health care industry is also subject to pervasive regulation from federal and state government, from the Joint Commission on Accreditation of Hospitals, and from third-party payors. For example, federal law requires each hospital to have an effective governing body which is "legally responsible" for the institution's conduct and which delegates to the medical staff accountability for the quality of care provided to its patients.[4] This delegation, however, does not remove the governing body from responsibility for the quality of care ultimately rendered in the hospital. One of the most painful reminders of this principle was a recent decision by the Georgia Court of Appeals which held a hospital liable for the negligence of its emergency room physicians, even though it was undisputed such physicians were independent contractors and not employees of the hospital.[5] If statutes and courts impose ultimate responsibility for quality of care upon the hospital and its governing board, then physicians must recognize that hospitals are entitled to a meaningful voice in quality of care issues. This is not to say physician input should be ignored. However, any hospital board which abdicates total jurisdiction over quality of care issues to the medical staff or which routinely rubber stamps medical staff recommendations is looking for trouble.

***If statutes and courts impose ultimate responsibility for quality of care upon the hospital and its governing board, then physicians must recognize that hospitals are entitled to a meaningful voice in quality of care issues.***

The tension caused by this concurrent jurisdiction over quality of care can explode into outright hostility when the spectre of malpractice is raised. Georgia was one of the first states to follow the celebrated *Darling*[6] case in Illinois and declare that a Georgia hospital could be liable for allowing an incompetent physician to practice in its facility.[7] The media have recently compounded the problem by publishing articles listing those hospitals which experience higher-than-average complication and mortality rates. Plaintiffs' lawyers jump for joy when they read such articles in their local newspapers, knowing that potential jurors will read them also. But when hospitals attempt to deal with quality problems though disciplinary action against incompetent physicians, other members of the staff are sometimes reluctant to take action against their colleagues. Is it any wonder why hospital administra-

tors then impose even more stringent limits upon a physician's exercise of medical discretion in the facility? These restrictions then lead to increased frustration among the medical staff, and the seeds of future conflict are inevitably sown. In an attempt to protect itself from the incompetence of a single physician, the hospital has alienated the entire staff. Once again, the laudable legal goals of the hospital have been obscured by the failure to communicate.

What lesson can be learned from this tale of woes? Perhaps that divorce is not inevitable provided hospital, physician, *and* legal counsel make a concerted effort to communicate. Lawyers must render advice with one eye on the law books and the other on the more practical issues at hand. When a hospital's decision is based upon legal grounds, it must explain its action to the medical staff in understandable terms. Finally, physicians should avoid hasty criticism of hospital decisions and realize that important legal justification for those decisions may be lurking just under the surface. While communication cannot be expected to end all hospital-physician disputes, perhaps it will at least establish an environment where such disputes can be discussed on a more rational basis.

***Physicians should avoid hasty criticism of hospital decisions and realize that important legal justification for those decisions may be lurking just under the surface.***

### Notes

1. Public Law 99-660; 42 U.S.C. §11101, *et seq.*
2. 42 U.S.C. §11112(b)(3)(A).
3. See Department of Justice letter to a preferred provider organization in Stanislaus County, Calif. (Oct. 12, 1984).
4. 42 C.F.R. §482.12.
5. *Brown v. Coastal Emergency Services, Inc.*, 181 Ga. App. 893 (1987), *cert. pending.*
6. *Darling v. Charleston Community Mem. Hospital*, 211 N.E.2d 253 (Ill. 1965), *cert. denied* 383 U.S. 946 (1966).
7. *Mitchell County Hospital Authority v. Joiner*, 189 S.E.2d 412 (Ga. 1972). ■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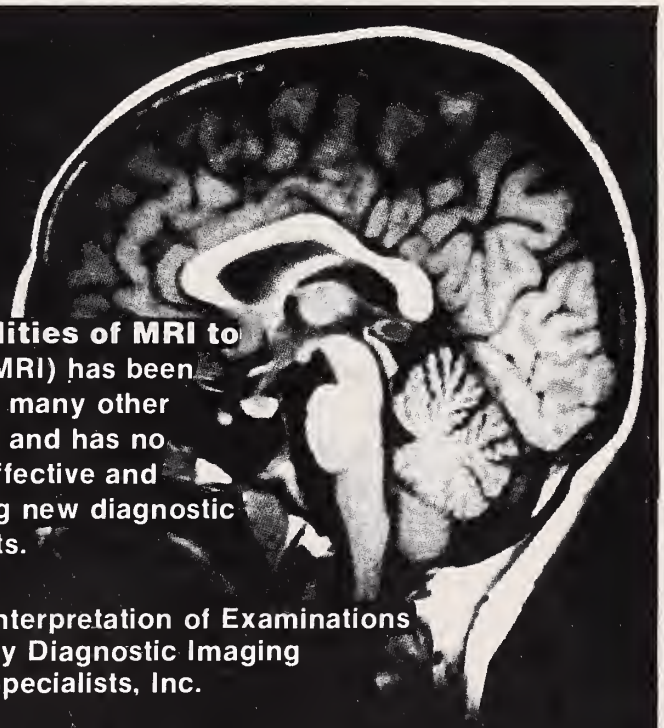

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# The Year 2000: A Look Into the Future of Hospitals and Medical Staffs

**W. Daniel Barker, F.A.C.H.E.**

## Overview

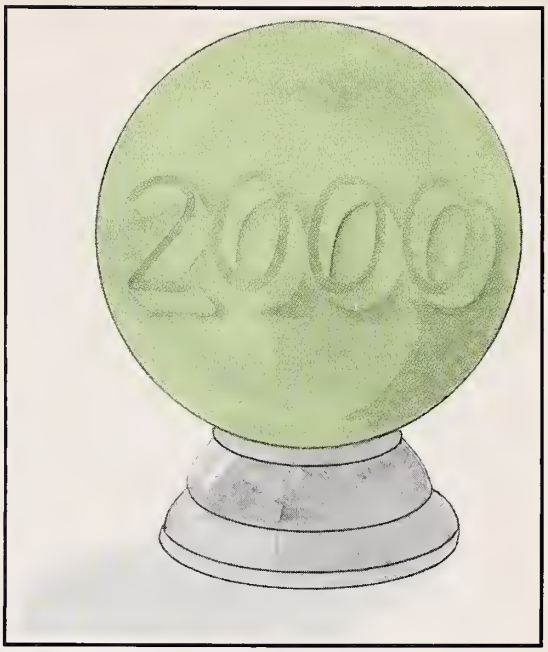
DURING THE LAST DECADE, health care has undergone drastic changes, and the future of health care will see even more. We are now able to make certain projections about what these changes will be by the year 2000. We expect that the number of physicians will increase at a greater rate than population growth; physicians may start their practice by becoming salaried employees rather than partners in a self-owned practice; statewide integrated hospital systems and multi-specialty group practices will dominate health care delivery; both patient and physician will have less control over their individual choices. With the family physician obsolete, the health care environment of the future will be more impersonal than ever. Health care financing will be dominated by employer managed care programs, and hospital/medical staff relationships will become the pivotal point in maintaining quality health care. Let's take a more detailed look at these issues.

Mr. Barker is Director of Hospitals, The Robert W. Woodruff Health Sciences Center of Emory University, 1440 Clifton Rd., Atlanta, GA 30322. Send reprint requests to him.

## The Changing Patient Population

Based upon projections by *GEORGIA: 2000,* a study which outlines future growth in the human and natural resources of the state, it is estimated that Georgia will reach a population of approximately 7,000,000 by the year 2000, an increase of about 2,000,000 people — over half of them immigrants — in less than 15 years. A report of this group recently stated that, "The migration of large numbers of Americans from the northeast and midwest sections of the United States to the states in the Sunbelt region will continue into 2000 at the same or increasing rates as we have experienced in the last several years. Georgia will continue to attract newcomers at a rate of about 60,000 to 75,000 a year. Uneven distribution of those immigrants within Georgia will increase the contrast within the state between rapid growing metropolitan areas and stagnant rural pockets. Georgians will grow older (the over-65 population will increase at twice the rate as the population as a whole)."[1] The report noted further that, "Individuals between the ages 25 and 44 make up the fastest-growing age group of Georgia's population. This is a common occurrence across the country because of the post World

**A most interesting look into the future — with creative and thoughtful projections of how things may be, based on the trends now in process, in the health care industry, especially as they relate to hospitals and medical staffs.**




War II Baby Boomers."[2] The other fastest growing age group includes those 65 years and older who come to Georgia not to work but to retire. Historically, cultures which grow more from immigration than from a natural increase, where births exceed deaths, find that this pattern causes dramatic shifts in traditional values, community relationships, and other social customs.

### The New Community of Physicians

Just as the shape of the patient population is changing, the community of physicians will also be altered significantly in the next decade. Based upon my projections from the American Medical Association Physician Master Files, and *The Environment of Medicine,* a Report of the Council of Long Range Planning and Development of the American Medical Association, it is estimated that in the year 2000, Georgia will have 13,618 physicians in practice. Twenty percent of these, or 2,720, will be female. Thirty-one percent, or 4,235, will be under the age of 35, and forty-three percent, or 5,874, will be between the ages of 35 and 45. Approximately one-fourth of the physicians in practice will be 45 years of age and older.[3] As a result of these trends, the number of physicians in practice will grow at a rate twenty-five percent faster than the population as a whole.

### The Physician of the Future

Let's look into my crystal ball at health care in the year 2000. Because of the high cost of education and the difficulty in starting a practice on their own, most young physicians after completion of their medical education in the year 2000 become salaried employees of a hospital, health care organization, or members of an established group practice. Physicians joining a group practice start as salaried employees and work toward becoming partners. Because of the expense of new technology and the high cost of operations, these salaried physicians have to "buy into" partnership status with a significant capital payment prior to becoming a partner. The career path in medicine has become very similar, in many respects, to that of large law and accounting firms. As a result, the real income level of physicians has decreased. Most physicians now work in group settings, and a significant number of them work as administrators and managers in their health care organizations.

In addition to the increasing number of younger physicians just beginning practice, we have more older physicians who are retiring from practice. Hospitals are purchasing more and more of these practices in a trend which is referred to as "practice acquisitions," whereby hospitals buy individual physician or group practices. In some instances, these practices are acquired prior to physician retirement. Such acquisitions assure a financial stability to the practice as far as the physician is concerned, and it guarantees the hospital that the practice will not be acquired by a competing institution or competing group practice.

### Technology and Health Care

As a result of new technology, the health care industry has become a very capital-intensive industry. Every new breakthrough in medical science has brought with it an enormous capital investment. The two factors that control the health care industry in Georgia, as well as in other places throughout the country, are patients and capital. As a result, we have large multi-specialty group practices and state-wide integrated hospital systems.

Care has become more impersonal. The "friend of the family" physician is a medical oddity and is virtually obsolete. Because of the significant growth in people in the 24 to 40 age group who have moved to Georgia for employment opportunities, we find that the employer is the most significant patient referrer for both hospitals and physicians. In the early 1990s, large employers found that they could package care like HMOs and remain in better control of their health care expenditures. As a result, managed-care programs — organized, operated, and mandated by large employers — became very numerous. These managed-care programs mandate physician panels as well as hospital participants. Because it is easier to choose among several hospitals than among thousands of physicians, employers and their employees choose hospitals, then the hospitals choose the physicians.

During the last 10 to 12 years, the use of longitudinal data-bases that trace a patient's experience, cost, and outcomes by hospital and physician have become prevalent. These data systems now provide a basis for setting standards and providing a valid assessment of the quality of health care delivered. As a result, individual reputations of physicians and hospitals are based upon the results of collective data.

Payment policy has also changed. The economic risk of illness has been shifted, almost totally, from the payers of care to the providers of care through capitation, negotiated rates, and fixed payment schemes. The competition between employer-mandated plans and HMOs continues to drive down the fees which hospitals and physicians charge.

Because of new technology, the number of patients admitted to hospitals as inpatients has been reduced by 50% during the last decade. Most surgical procedures are now performed in an outpatient or ambulatory setting. As a result, the number of hospitals in Georgia has decreased from almost 200 in 1987 to less than 100 in the year 2000.

Technology has radically revolutionized the health care field. Dr. Jeff Goldsmith, author of *2036: A health care odyssey,* has noted that, "Thanks to improved anesthesia and to advances such as laser surgery, fiber optics, and high-tech catheters, entire surgical disciplines have been transformed into specialized forms of 'bioplumbing.' Ophthalmology has virtually disappeared from inpatient hospital setting as well as urology, plastic surgery, and gynecology. Advances in catheter technology have enhanced the safety of critical care monitoring as well as transformed cardiology from primarily a diagnostic discipline to an invasive, curative one."[4]

**As a result of new technology, the health care industry will have become a very capital-intensive industry. Every new breakthrough in medical practice will have brought with it an enormous capital investment.**

New technologies, which now make it possible for patients with serious illnesses to be discharged from the hospital faster and more safely, are largely the results of microprocessor technologies which have made possible the administration of sophisticated chemotherapy at sites remote from the hospital.[5] Parallel advances in monitoring technology have produced sophisticated multifunction monitoring systems such as the ambulatory computer that monitors, evaluates, stores, and sends to remote locations signals that indicate patient distress or risk.[6]

### The Integrated Hospital System

Each of the four medical schools in the state has organized its own vertically integrated hospital system. These systems provide employment opportunities for their graduates, a source of payments for faculty practice plans, and an educational experience for their students. Each system has at least one tertiary referral center surrounded by a ring of geographically dispersed secondary hospitals and a still wider ring of rural ambulatory and emergency "entry points" to the system. The ambulatory and emergency care units have replaced the primary care hospital of the 1970s and 80s.

Each tertiary referral center, each secondary hospital, and each ambulatory or emergency entry point into the system is connected, according to Goldsmith, "by webs of telemetry similar to those used in cellular communications"[7] years ago, and are coordinated and monitored by computer systems. Artificial intelligence application in medicine has matured and increased the productivity of all health care workers. Intelligent clinical information systems have become the integrated hospital's systems operating core, interacting with physicians and nurses in diagnostic decision making and patient management. These systems monitor patient conditions on a real-time basis, tracking physiological signs and incorporating test results, comparing patient responses against profiles gleaned from vast clinical bases, and assisting the physician and other members of the patient care team in evaluating and planning care.[8]

Integrated statewide hospital systems now have the capability of machine-to-machine transmittal of clinical information. Goldsmith summarized this scenario, clinical information systems combine text and images in new storage and retrieval modes such as the writable laser disc that has replaced the paper medical record. Today, information transmittals contain both high resolution visual images of specimens or affected body parts as well as oral or written commentary from the consultant.[9]

This new technology now permits the medical school's faculty practice plan to become the regional medical staff for their system. It consists of a central core of specialists and a broad primary care base. In addition to the full time medical school faculty, the medical staffs of these systems also have physicians that staff the remote clinic units of the system. In this role, the primary care physician is the authorized point of first contact and either provides or authorizes all the care appropriate for the problems which the patient presents. In addition to these four medical school related systems, Georgia also has two for-profit and two not-for-profit statewide systems organized along similar lines except for the faculty practice plans and the tertiary referral centers.

### The Hospital of Tomorrow

Because of the competition which is prevalent, new marketing techniques have caused the hospitals to reorganize their medical services. Wellness programs, adolescent behavioral medicine units, cancer centers, joint replacement and organ transplant programs have grown. Hospitals have created these types of "specialty lines" in tune with the marketing programs of the day. Today, women's health care centers, elder care programs, cancer care programs, arthritis centers, organ replacement centers, diabetes treatment programs, and eating disorder units have replaced the traditional departments of medicine, surgery, pediatrics, and obstetrics.

Hospitals have copied the 1980s marketing theme of the computer industry and have become "patient friendly." The medical staff of today's market-driven hospital is organized

accordingly. As an example, the patient with cancer does not know whether he needs medicine, surgery, chemotherapy, or radiation treatment. He only knows that he needs cancer treatment. Hence, the cancer center has taken the place of traditional departments. Physicians are assigned to "product lines," not to clinical services. As a result, certain internists have privileges in the cancer center, some in the wellness program, and others in a women's center. Because of their specialty, surgeons may be credentialed in only one product line. Medical staff organization as well as medical education continues to move toward specialization.

### Hospital/Medical Staff Relationships

Because of these factors, medical staff organization has changed significantly. The medical staff participates in both policy formulation and professional management to a greater extent than in the past. The medical staff plays an important managerial role in technology assessment, product line management, and cost effective clinical decision-making. In the year 2000, hospitals need their medical staffs to help them be vertically integrated, to control cost and to succeed in the market place. At the same time, physicians need their hospital because the hospital provides management expertise, is the capital conduit for joint ventures, and markets the physicians' services.

One of the greatest challenges in the year 2000 for both hospitals and their medical staffs is to make certain that the control point in medical care does not pass from the physician. As patient populations are increasingly managed by hybrid provider organizations for capitated payments, the ethical dilemmas increase as the basic business ethic takes its place alongside the service ethic. Physicians in the year 2000 continue to value their professional autonomy, that is, their ability to avoid third party mediation in what they believe to be best for their patients. In the year 2000, professional autonomy hinges on economic autonomy.

### The Impact of Today's Hospital/Medical Staff Relationships Upon the Future

There is an old saying, "Forecasting is a difficult thing — especially when it deals with the future." My crystal ball is no clearer than anyone else's and may, in fact, not be as clear. To a certain extent, our future will depend upon ourselves. Some even say that we deserve the future that we get. Although it is impossible to predict with total accuracy the relationships between hospitals and their medical staffs in the year 2000, we can predict that the future will be much brighter not only for ourselves but for the patients we serve, if we have right relationships between hospitals and their medical staffs. Recently, Omega Research Consultants, Inc., Chicago, and *Hospitals* magazine conducted an informal survey of 100 physicians nationwide to determine what physicians really want from hospitals. Among the answers were good patient care, better communications, quality care measurement, and mutual trust.[10] It is important that hospitals and their medical staffs make certain that the right relationships exist. I believe we will find that the relationships between the medical staffs and the hospitals will determine whether professionally directed and locally controlled medical staff organizations will survive. ■

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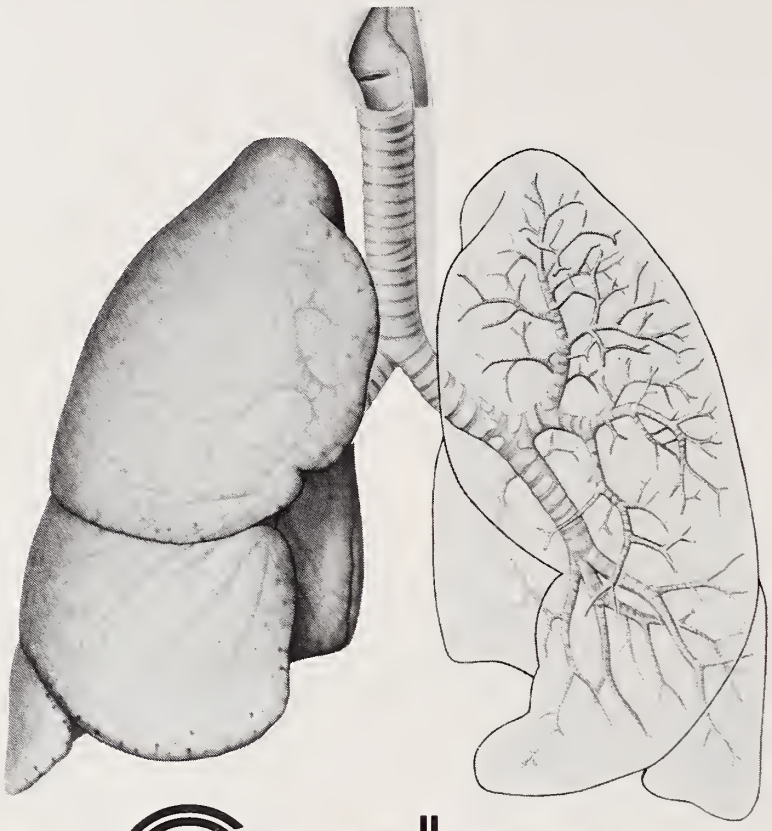

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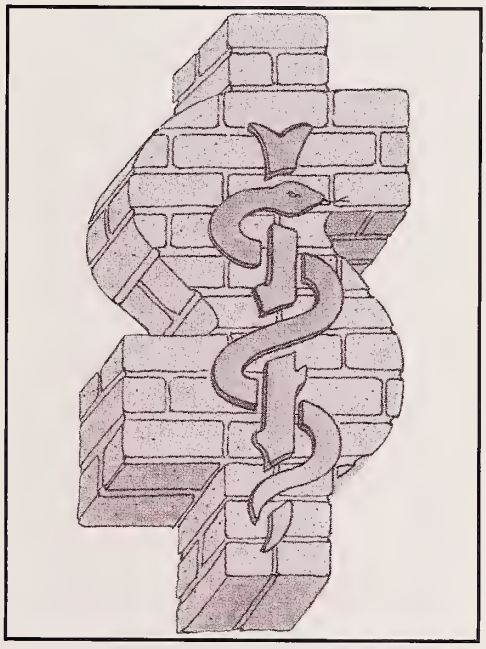
# The Challenge of a New Financial Perspective

## *How It Affects The Hospital/Physician Relationship*

**Glenn J. Black**



A RECENT CABLE NETWORK presentation featured Joseph A. Califano, the former Secretary of Health and Human Services, speaking on the subject of today's health care environment. In his remarks, he referred to a virtual health care revolution taking place in this country dealing with the serious questions of who lives, who dies, and who pays. He classified physicians as the high priests of today's health care society because only they know where and how to treat us, what to prescribe, and will determine, to a large extent, how much we will pay for those health care services. Indeed, today's health care marketplace is undergoing dramatic and revolutionary change.

Change is a way of life for most businesses. What makes this change so profound in the health care field is that the very structure of the industry is in a state of transition. As you might suspect, the cause of change is largely economic. The big purchasers of health care (i.e., government through the Medicare and Medicaid programs and private industry through employer and employee-financed health benefit plans) determined that health care costs should be controlled and set about introducing new payment and health care delivery systems to begin the transition.

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From the federal government perspective, the most significant development since the enactment of Medicare was the initiation of the Prospective Payment System (PPS) which essentially created a federal price list for about 470 Diagnosis Related Groupings (DRGs) and ended the government's previous open-ended financial risk associated with Medicare payments for hospital services. PPS was intended to create new incentives to control costs by eliminating the former cost reimbursement formulas (i.e., the more you spend, the more you get).

Employers in the private sector responded in equally dramatic fashion as they resolved to manage health care benefits as any other cost of doing business. Con-

sequently, a second key development in the transition began to emerge — the growth of alternative health care delivery and financing systems (i.e., Health Maintenance Organizations and Preferred Provider Organizations). The number of HMOs has risen from 30 in 1972 to over 400 today; enrollment has risen to well over 20 million people. The number of PPOs has increased from 64 to over 400 in 3 years. Now, employers are involved more frequently in decisions about where and under what conditions hospital services will be paid for and at what prices.

***The Prospective Payment System (PPS) was intended to create new incentives to control costs by eliminating the former cost reimbursement formulas (i.e., the more you spend, the more you get).***

Traditionally, hospitals have depended upon physicians to use their services and fill their beds to reasonable capacity. The competitive forces at work since the initiation of PPS and the emergence of alternative delivery systems no longer compensate for the maximum utilization of services. Today, hospitals are essentially considered institutions of last resort. Furthermore, fixed payment rates (e.g., DRGs and per diem or per case rates negotiated by HMOs or PPOs) establish price ceilings which place the hospital at risk for the cost of services utilized beyond those pre-determined rates.

Given this scenario, it's no wonder that the relationship between hospital and physician is being sorely tested. Physicians remain the central care giver; they put patients into hospitals, order the tests, prescribe the treatment, and interact with local hospitals. (Direct physician services account for about 22 percent of personnel health care expenditures; however, 70 to 80 percent of all health care expenditures are attributed to decisions made by physicians.) While managed care programs have emerged to monitor physician and hospital utilization, particularly in the area of inpatient services, physicians largely remain in charge, as they rightly should, of the world of medicine. However, given the more limited reimbursement available to them, hospitals are faced with serious financial dilemmas. The physician's decision about patient admissions, length of stay, and the ancillary services and diagnostic work provided during the stay, all affect payment under PPS or other negotiated payment arrangements. In the past, before PPS, the physicians who admitted the most patients, ordered the most tests, and generated the highest gross revenue were the hospital's heroes. That's no longer true, and hospitals are faced with the unpleasant task of dealing with the concept of winners and losers. When a physician becomes a greater liability, financially speaking, than an asset to the hospital, it's inevitable that organizational concerns (i.e., the hospital's financial viability) will clash with a physician's individual judgment about treatment protocols. Many hospital boards of trustees are having to evaluate the "economic credentials" of physicians as well as their professional credentials. So, more than ever before, physician practice patterns have to be discussed, cost-management strategies explored, and accurate information exchanged about delicate financial issues balanced with quality of care concerns.

Ideally, this dialogue should occur in a congenial, cooperative environment. In reality, however, conflicts are inevitable. Pressures on both hospitals and physicians can be attributed to the more competitive health care marketplace. Urgent care centers, owned and operated by hospitals can be viewed as threats by physicians when, in reality, the hospital's real purpose may be to protect referral patterns for its own medical staff. Attempts to explain pre-admission certification or mandatory second opinion requirements by private insurors can be interpreted as interference in a patient relationship and beyond the purview of nonmedical personnel. Sensitive and complex negotiations with HMOs or PPOs, intended to preserve the patient base for both the hospital and its medical staff, may appear to cause unnecessary pressure to participate on the part of an individual practitioner. Likewise, the failure to execute a contract when competing institutions do participate fosters criticism when physician practices are adversely affected.

***In the past, before PPS, the physicians who admitted the most patients, ordered the most tests, and generated the highest gross revenue were the hospital's heros. That's no longer true. . . .***

Similarly, hospitals may regard certain physician initiatives as an intrusion into the hospital's turf. Many of the same competitive forces adversely affecting hospital utilization may be threatening office visits or patient referrals to physi-

cians. It's only natural to think that new opportunities will be pursued by physicians experiencing reduced patient volumes and income.

***Many hospital boards of trustees are having to evaluate the "economic credentials" of physicians as well as their professional credentials.***

Earlier, the hospital considered physicians solely as customers. The health care business was unique in that the consumer of services (i.e., the patient) was not the customer. Those days were simpler since the hospital simply provided the facility and diagnostic tools needed and requested by its physicians (i.e., the customer) without undue financial risks associated with bad decisions. Capital financing was relatively cheap and fully reimbursed by Medicare and other payors. Today, hospitals are often confused as to whether the physician is a customer, competitor, or partner. Furthermore, the consumer is demanding more information and participating in health care decisions more frequently. Responding to consumer demands for preferred health care services often runs headlong into the perceived domain of others. Thus, well-intentioned responses to market forces raise unintentional confrontations.

Frustrations can also arise due to a few fundamental differences in the perspectives of hospitals versus those of physicians. Hospitals are organizations where actions and decisions are determined by concensus (or policy). They must serve the interest of many groups concurrently without becoming too discriminatory in their practices. Physicians, on the other hand, are largely oriented to one group of patients and are conditioned to an efficient, yet individualized, decision-making process. They represent themselves. It's possible for physicians' interest and enthusiasm to be quickly dampened when suggestions and recommendations, uniquely applicable to their own particular segment of patients, strikes a perceived unresponsive chord when the hospital is forced to deliberate the broader issues related to maintaining a reasonable degree of consistency, equity, and fairness.

Conflicts are inevitable in today's environment — but the primary goal should be to foster the spirit of cooperation and to minimize the opportunity for conflict. We need a cooperative spirit.

How can we preserve the hospital/physician relationship during these turbulent times? While local circumstances will influence the best ways to strengthen relationships, the key to success is communication. Without effective communication among physicians, board members, and management, the strain will become unbearable.

While good communication is the foundation for a cooperative relationship under today's financial stresses, the following practices are a few that should be considered:

- *Starting at the top,* it's a good idea to have participation by physicians on the governing board. This tradition has been endorsed by the American Hospital Association and American Medical Association and represents a way for the entire board to understand physician perspectives while affording the medical staff with representation in the policy-setting process.
- *The strategic planning process* should solicit the views of medical staff leaders as the hospital pursues alternative courses of actions dealing with the outside conditions of change. Hospitals no longer have simply facility plans, but are forced to evaluate services and products as well. What hospitals do is no longer a function of board or management ambition and desires but a response to the external influences of the competitive marketplace. Physicians can and should play a significant role in long-range planning.
- *The short-range planning process* should likewise seek the advice and counsel of the medical staff organization. Capital budgeting, in particular, should assure that scarce capital resources are allocated according to concensus priorities for replacement and new medical technology needs.
- *Cost-effective health care service innovations* can often be more easily fostered after communication barriers are lifted, suspicions are relieved, and awareness is promoted. Educational efforts to heighten the level of awareness about the new health care issues offer substantive and often surprising results and new ideas without forcing preconceived outcomes. Medical staff committees, given appropriate information, provide an excellent structure for physicians to study sensitive clinical and cost issues and arrive at thoughtful conclusions about cost-effective patient care.
- *Outside the organized medical staff,* business arrangements between hospitals and physicians are occurring. These joint ventures have been viewed with some skepticism by both parties, and many have left disillusioned and dissatisfied "partners" with unmet expectations. While the *potential* for improved relations with physicians exists through joint ventures, risks are present. Too often the fundamental aspects of these arrangements are

either ignored or reduced to secondary considerations — that is, the goals and expectations of the venture and the basic need for the proposed activity in the first place are poorly defined. Many, intended to reduce conflict and foster cooperatioin through sharing economic risks and rewards, have simply antagonized other physicians. Others raise conflict of interest concerns regarding how quality care can be provided while maintaining an economic interest in how it's delivered. It's been said that partners are those who share a common mission. The successful joint venture must assure that a true partnership develops.

- *In this age of marketing,* the physician can be a key member of the marketing team. While advertising can be distasteful to some and considered unethical to others, the recent trends in utilization have stimulated the interest in marketing concepts. Hospitals are having some success in reversing declining utilization trends through aggressive public awareness campaigns backed by sound market research. Since physicians can influence the perception of the hospital by their patients, marketing functions should consider the involvement of physicians.
- *Finally,* hospitals may be able to strengthen its relations with physicians by providing assistance in certain specialized areas. It may be possible to extend the hospital's expertise in certain functions to the physician's office practice. Such activities as employment screening and referrals, computerized sharing of clinical information to save valuable physician time, billing and collection services, and purchasing assistance are a few that, if properly developed, can help to bond the hospital and the physician.

Regardless of the approach to strengthen the hospital/physician relationship, given today's strong financial incentives to do so, the bottom line is being a cost-effective provider of excellent care. You cannot do that without physician involvement and participation in the process. When hospitals and physicians cooperate, both sides can win.

During periods of turbulent change, it's easy for the organization's goals to become distorted and confused. One point is clear — the patient is, and must always be, the ultimate beneficiary of our collective efforts. The challenge is to serve the patient's best interest through judicious resource use. ■


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# THE GEORGIA HOSPITAL ASSOCIATION

## *What it is, what it does*

**Max L. Brabson, Joseph A. Parker**

THE GEORGIA HOSPITAL ASSOCIATION (GHA) is both leader and spokesman for the hospital industry in Georgia. As health care continues to demand new hospital services and delivery systems, GHA is the one state organization to which hospitals of every size and type can turn for representation and advocacy.

GHA's members represent nearly all the hospitals in Georgia. Thus, the association's interests center around the major forces affecting the industry as a whole. Basically, those forces are the following:

- *Cost.* Hospitals, which account for 40% of the health care bill, must continue to provide the best health care services possible and at the same time contain the cost of those services.
- *Competition.* Cost containment efforts coupled with dwindling Medicare and Medicaid reimbursement create intense competition among health care providers.
- *Changes in delivery of health care.* To strengthen their capacity to provide health care, many hospitals are restructuring or adopting horizontal consolidation, vertical integration, and networking systems.
- *Business accountability.* Today's hospitals must account for their performance as businesses as well as health care providers.
- *Changes in physician relations.* In response to cost containment's pressure, hospitals and individual physicians, as well as groups of physicians, are setting up new types of relationships.

Because of those forces, GHA faces a number of issues, the most urgent of which are the survival of many small and rural hospitals and the financing of indigent care for all hospitals. To help its smaller hospitals, the association is supporting on the national level a higher Medicare reimbursement increase in 1988 for rural hospitals as well as special consideration for their outlier and swing bed reimbursements. It is also working to achieve nursing home acceptance for patients requiring higher levels of care and for government permission to devote unused beds to long-term care. GHA has taken an aggressive stand on indigent care, requesting that the Department of Medical Assistance increase the Medicaid eligibility level to the current federal poverty level and working for a state-appointed task force to suggest new ways to finance indigent care, which the association believes is a societal responsibility.

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GHA is one of the most effective voices for health care in the state legislature. During the last General Assembly, GHA lobbied successfully for the passage of tort reform as well as for measures affecting hospital reporting, peer review programs, and data collection. It also speaks for hospitals in regulatory matters governing issues such as Medicare and Medicaid, capital expenses, professional performance, personnel licensure, quality, utilization, patient rights, and employment practices. It is the hospital advocate on issues before the State Board of Nursing, the State Health Planning Agency, the Georgia Department of Human Resources, the Joint Commission on Accreditation of Hospitals, and the national and regional offices of the Department of Health and Human Services. Further, it acts as liaison between the industry and the Medical Association of Georgia, the Georgia Medical Care Foundation, fiscal intermediaries, third-party insurers, and business coalitions on health care.

***"GHA's members represent nearly all the hospitals in Georgia. Thus, the association's interests center around the major forces affecting the industry as a whole."***

Additionally, GHA offers programs and services to help its member hospitals operate effectively and respond to the new forces in the industry. GHA sponsors an employee benefits program, third-party collection assistance, information system consulting, telecommunications consulting, and a claims review system to reduce insurance audits. GHA's communications service keeps hospitals up-to-date on events affecting their operations and coordinates their contact with the mass media. Data services produce information on patient demographics, salaries, charges, and utilization. The Georgia Hospital Insurance Agency, GHA's for-profit subsidiary, provides property and worker's compensation insurance coverage, and the separate non-profit Research and Education Foundation holds educational seminars and workshops throughout the state as well as on TELNET, its telecommunications system.

The association's membership includes 187 acute care and psychiatric hospitals. They number 92 institutions governed by hospital authorities, 54 investor-owned, 35 not-for-profit, two federal, two state, and two church-related hospitals.

Besides its institutional members, the association has another group of 40 associate members who have business or professional relationships with member hospitals. Associate members keep GHA's hospitals in touch with the organizations that provide services to benefit health care delivery.

Another key membership group is the more than 1,500 individual or personal members in any of 14 affiliated societies of hospital professionals. Those members represent hospital engineering, personnel, nursing, public relations, social work, purchasing, education, law, utilization review, telecommunications, volunteer services, patient representation, quality assurance, and pastoral care. Through the societies, members exchange ideas and information and increase their knowledge in their individual professions. The societies also enhance GHA's understanding of the professions that make up the hospital organization.

In representing and providing services to the institutions as well as to the organizations and individuals who carry on the business of providing health care to Georgia, GHA is the recognized leader of the hospital industry. Its wide base of members enables it to speak for all hospitals. It is the unifying factor for hospitals in government issues, in business matters, and in helping its members adapt to the ongoing changes in the delivery of quality health care. ■

Presumably, Dr. Codman would be pleased to see the results which his fertile concept has spawned. Organizations in all major divisions of health care, and in every state and territory, secure accreditation, utilize publications, attend education seminars, and seek consultation from the Joint Commission. Accredited organizations generally find that enhanced community prestige is matched by heightened professional confidence which fosters reimbursement, staff recruitment, and educational affiliation opportunities not otherwise available.

***Through these initiatives, accreditation standards are to be streamlined, and a more relevant survey process which incorporates ongoing monitoring of clinical performance at the organization level is planned for implementation by 1990.***

Over time, the medical staff standards have forged an important linkage among effective credentialing, coordination with organizational structure and function, and the physician's role in quality assurance. These national standards have created a framework for medical staff committee activities and for the peer review function which is so vital to achieving high quality care. Performance norms for hospitals and their medical staffs, now expressed as specific scoring guidelines for each Joint Commission standard, have replaced subjective judgements and convictions.

Quality assurance activities and risk management functions related to patient safety clearly emphasize the importance of a team approach to fostering better care and prevention of patient misfortune. Without regard to financial considerations, risk and liability exposure today are being reduced by the monitoring and evaluation approach which Dr. Codman envisioned so many years ago.

But the second part of Dr. Codman's dream remains as a challenge to be met. To the present time, neither the available data management technology nor, quite frankly, the will of the profession have provided a foundation for exploring the potential applications of patient outcome information. But times are changing. Late last year, the Joint Commission announced a series of initiatives to address this need as well as others. Through these initiatives, accreditation standards are to be streamlined, and a more relevant survey process which incorporates ongoing monitoring of clinical performance at the organization level is planned for implementation by 1990.

### Agenda for Change to Balance Outcomes, Structure, and Process

In 1979, the way for the envisioned transformation of the accreditation process was paved by the adoption of the Joint Commission's quality assurance standards.

These standards require organizations to monitor performance in an objective and systematic fashion, to identify needed improvements, to take corrective actions, and to demonstrate the effectiveness of these actions. To date, health care organizations have shown highly variable compliance with these important standards. Truly effective quality assurance systems are rare indeed. But the need to develop and implement these systems is now a matter of self-interest for hospitals and physicians. Happily, the necessary technology, including sound software packages, and demonstrably effective quality assurance methods are rapidly becoming available, and the resurgent interest of professional specialty organizations in establishing national clinical performance standards and performance criteria is a reflection of the fact that our professional will is very much alive and steadily strengthening.

As the new methodology unfolds, valid, measurable indicators of clinical performance must be combined with emerging approaches to adjusting for severity of illness and other important patient variables. In a parallel effort, existing standards are to be refined to assure their relevance to quality of care; this effort is expected to result in curtailment of the length of the current standards manuals. Through appropriate pilot testing, the clinical performance indicators will be honed to establish their linkage with quality improvement opportunities in each of the specialty areas as well as hospital-wide functions which impact all services and procedures.

Clinical data gathering will begin in 1987. Many hospitals have already volunteered to become test sites, and a representative mix will be selected for trial activity in 1987 and 1988. Further refinement and testing at a wider selection of hospitals will follow in 1989, with the launching of the new accreditation process scheduled for 1990.

### Building on Scientific Consensus

The challenge of developing a new outcome-oriented accreditation process is significant simply because of the amount of work involved and the need to draw upon a broad range of professional expertise. Professional expertise will provide the underpinnings not only

for the content but also for the credibility of the clinical performance measures which are eventually selected.

It bears emphasis that numerical performance measures are not the end point in this new process. Rather, they became a vehicle for identifying important patient care problems within the context of the existing quality assurance process. Thus, the end points continue to be problem analysis, peer review, and demonstrably effective action.

Further, the need to be parsimonious in selecting measures is apparent. Ultimately, responsible physicians must understand, interpret, analyze, and act upon the data. Therefore, measures must be carefully selected, and the data produced must be manageable. These requirements only serve to emphasize the importance of sound professional guidance in the developmental process.

The initiatives described above are being guided by the Accreditation Project Steering Committee which consists of Joint Commission Board members and experts in areas particularly relevant to the initiatives.

Members from the Joint Commission Board of Commissioners:

**Ceylon S. Lewis, Jr., M.D.,** Immediate Past President of the American College of Physicians;
**M. J. Jurkiewicz, M.D.,** American College of Surgeons, Professor of Surgery at the Emory University School of Medicine;
**Robert E. McAfee, M.D.,** Trustee of the American Medical Association, and a principal in the Maine Medical Assessment project;
**Charles A. McCallum, D.M.D., M.D.,** President of the University of Alabama/Birmingham and Chairman of the JCAH Board of Commissioners;
**George H. Schmitt,** Trustee of the American Hospital Association and President of Forbes Healthmark.

Members at large:

**Paul F. Griner, M.D.,** Director of Strong Memorial Hospital in Rochester, New York, and an eminent scholar of diagnostic and clinical procedure effectiveness;
**Lincoln E. Moses, Ph.D.,** Professor of Bio-statistics at Stanford University and an internationally known expert in health care statistical analysis;
**Stephen M. Shortell, Ph.D.,** Professor in the J. L. Kellogg Graduate School at Northwestern University, and an expert in organizational functions;
**John E. Wennberg, M.D.,** Professor of Preventive Medicine at Dartmouth Medical School and widely-published analyst of clinical treatment variation studies.

The first-year work plan calls for four focused Task Forces which have now been appointed. Their membership includes 46 scholars and professionals from a wide variety of disciplines. These Task Forces are developing indicators of quality in the following areas:

- Hospitalwide clinical performance
- Organization and management functions
- Anesthesia care
- Obstetrical care

Ultimately, individual Task Forces will address over 30 clinical and organizational performance areas. Staff support is being provided by an expanded Joint Commission department of research and development consisting of more than 20 scientists and data analysts.

### Clinical Quality Indicators — The Key Ingredient

Concerns have been expressed that the Joint Commission intends to attempt direct measurement of quality, via data analysis, from Chicago. No such effort is contemplated. The developmental plans do include the establishment of an interactive database capability between hospitals and the Joint Commission. This capability will offer hospitals the opportunity to compare their performance with similar hospitals and thereby enhance their problem identification efforts. This correspondingly will permit the Joint Commission to monitor hospital problem identification and resolution on an on-going basis.

Indeed, the principal focus of Joint Commission review activities remains in assuring that organizations are meeting their own monitoring and problem-solving responsibilities. This is based on the longstanding thesis that quality monitoring programs are effective only when they become woven into the fabric of the organization's culture. No external review body can or should substitute itself for this process.

***The principal focus of Joint Commission review activities remains in assuring that organizations are meeting their own monitoring and problem-solving responsibilities.***

The revised approach to accreditation is expected to lead to changes in the survey process as well. In a data-driven system, data quality and validity clearly require scrutiny. The increasing clinical focus of the survey will also necessitate attention to the problem analysis and peer review processes to assure that these are indeed substantive and conscientiously performed. Finally, management effectiveness in supporting patient care activities must be carefully evaluated. While the survey is designed

as an evaluation activity, it is also intended to provide hospitals with constructive guidance in meeting their quality assurance responsibilities.

***These standards require organizations to monitor performance in an objective and systematic fashion, to identify needed improvements, to take corrective actions, and to demonstrate the effectiveness of these actions. To date, health care organizations have shown highly variable compliance with these important standards.***

The Joint Commission initiatives also include broadened educational, consultative, and communication efforts. Joint Commission publications and educational seminars now place primary emphasis upon providing practical suggestions, including examples, and the scope of these activities is expanding rapidly. The Joint Commission subsidiary, Quality Healthcare Resources, Inc., offers a range of consultative services to assist hospitals in improving their quality assurance efforts. The Division of Education provides a series offering of their television programming on topics of major interest through a contract with Hospital Satellite Network.

Meanwhile, communication bridges are being developed with target audiences which have developed a keen interest in quality of care issues. Those include corporate purchasers, insurors, and consumer groups, among others. The purpose of this activity is to ascertain the perceived needs of these groups and to represent to them the professional commitment to provide high quality care. Understanding the needs and concerns of these grouups should make the Joint Commission more effective in providing support to hospitals and physicians.

The Agenda for Change initiatives are ambitious, but they are achievable. The developmental efforts are starting with hospitals, but in a staggered time frame, they will expand to include the other types of organizations involved in Joint Commission accreditation activities. The primary intent is to do this job well as opposed to quickly. Progress to date suggests that this objective can be met within a reasonable time frame.

Obviously, a project of this magnitude is expensive. Grant funds have already been received, and more can be expected. At the same time, it is necessary that the organizations which stand to benefit from this effort also bear a reasonable portion of the costs.

### Challenges and Costs for Organizations and Clinicians

Notwithstanding the self-interest imperatives, hospitals and physicians have been slow to develop and implement effective quality assurance programs. Explicit commitment to this task by medical staff and hospital leadership is often lacking, and it is the rare hospital that has provided as much as 1% of its expense budget to support these activities.

By contrast, major business corporations commonly assign 3-5% of their budgets to quality control and quality assurance activities. They do so not out of altruism but because their survival and competitive posture requires this effort. Physicians and hospitals are not far removed from this reality in the current environment. Indeed, corporations often find that the quality assurance investment results in major savings. In the world of patient care, it is difficult to avoid the conclusion that avoiding complications and adverse outcomes will also result in significant savings, including professional liability costs.

What can hospitals and physicians do now? The most compelling need is for these principals to immerse themselves in learning how to manage and interpret clinical data. Some are sitting on the sidelines "waiting to see what the Joint Commission does." That could be a fatal mistake. Government, business, insurors, and even the media are moving aggressively to gather and interpret clinical performance information. Those directly involved in providing care may fall short of perfection in selecting performance criteria, but most are well aware of the important services they undertake and the risks entailed in these services. Failure to develop internal monitoring systems creates an untenable vulnerability through making it virtually impossible to respond to external data releases and sensational news stories. The Joint Commission will actively support physician and hospital efforts, but as a practical matter that support should occur in parallel with these efforts.

To date, hospitals and physicians have offered strong encouragement for the Joint Commission initiatives. That encouragement is gratifying, but it is also essential. Quality of care is today a major public policy issue. This arises from the fundamental values of our society and is a reflection of the concern that limited resources pose a tangible threat to the quality of available services. The Joint Commission, physicians, and hospitals must address this reality in the most constructive ways possible. The time has come to fulfill Dr. Codman's dream. ■

# PRO GEORGIA 1987

**Luther M. Thomas, Jr., M.D.**

THERE HAS BEEN NOTHING in the history of medicine in this country to compare with the changes that have occurred since the enactment of the Medicare law in 1966. The federal money invested in medical care as a result of the Medicare law has resulted in great expansion of facilities and personnel and has been called the Golden Age of Medicine in the United States. The laws and regulations that were enacted during the succeeding 20 years have tested the integrity of the medical community to the limit. The grand purpose of the Medicare Act to give the eligible citizens of the country complete medical care quickly met the harsh reality of fiscal cost. The result was the creation and evaluation of review programs that are now called Peer Review Organizations.

The laws and regulations that govern peer review are primarily cost containment guidelines. The laws usually start as amendments to funding or budget bills in Congress. As payment restrictions became tighter, the pressure from the public and the medical sector resulted in the addition of quality measures in order to protect the Medicare beneficiary from the imagined abuses that cost containment might stimulate. During the past 20 years, the review process has progressed from simple utilization review to professional standards review organization (PSRO) to peer review

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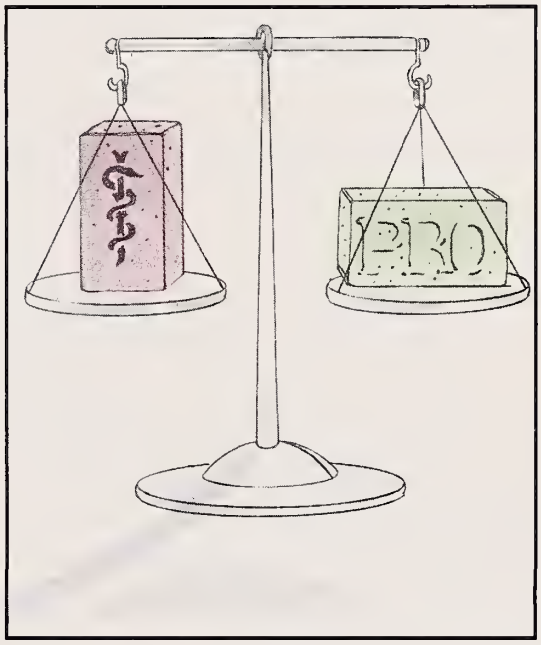


**It is the physician's responsibility to gain education and information concerning PRO activity, and hopefully, participate as a reviewer, in order to protect the integrity of the current system of medical care.**

organizations (PRO). The process has created diagnostic related groups (DRGs), quality review, sanctions, public release of data to enlighten the consumer, and the encouragement of capitation payment plans. You can safely bet your farm that further efforts to reduce costs and penalize decreases in quality of care will occur despite the incongruity of the two efforts. The hospital industry, physicians, recipients (Medicare beneficiaries), and taxpayers can have an effect of these changes through communication with legislators concerning pertinent bills and proposed regulations in the federal register and through their vote.

**You can safely bet your farm that further efforts to reduce costs and penalize decreases in quality of care will occur despite the incongruity of the two efforts.**

The cost containment aspect of peer review is the oldest and best known. Hospital administrators and physician medical staffs have, of necessity, worked together to implement the required changes in patient care. The scope of review has increased and become more specific (focused). The latter is an effort to follow Sutton's Law — because that's where the money is. Focused review can be expected to change as the medical community adapts and alters methods of doing things. The old basic utilization review procedures have continued through the years with some alteration. The PRO contracts include required utilization review objectives:

1) Decrease admission rates for certain DRGs.
2) Short stay (1 to 2 days review).
3) Focused reviews:
   a. Rehabilitation.
   b. Unexpected operating room procedures.
   c. Chronic obstructive pulmonary disease.
4) Readmission within 15 days.
5) Certain principle diagnoses.
6) Transfer between institutions.
7) Day and cost outliers.
8) Certain prospective payment system units.
9) Lithotripsy.
10) Preadmission review of some specific procedures.

Quality review has created a great deal of misunderstanding, negative reaction, and hostility. The inexperience of both the Health Care Financing Administration (HCFA) planning staff and the PROs with the new review created many of the problems. The natural resentment of both hospitals and physicians aggravated the situation. The required data release to the media inflammed the issue to a greater degree. Data through 1987 included 17,778 physician case reviews with only 492 (2.8%) having quality problems of any level. Only one physician has required sanction activity, and three are pending, all on corrective action plans. Only three hospitals in the state have received quality problem determinations.

Quality review is an important feature of peer review, perhaps the most important. It can be beneficial to all concerned if the emphasis is placed on communication and education. The first step of quality review is done by a nonphysician reviewer using a generic criteria screen of the medical record. Each hospital should have a copy of this screen. A record that fails to meet the screen criterion is referred to a physician reviewer who evaluates the finding of the primary reviewer. If the physician reviewer concurs with the primary review, the attending physician is asked to send additional information relating to the questioned area of quality review. When the additional information is received, the case is reviewed by a second physician in the specialty of the physician under review. If the second physician reviewer feels that the additional information is not sufficient to change the decision, the attending physician is notified that the PRO has determined that there is a confirmed quality question, and the case is filed. If a physician receives enough confirmed quality cases to reach the threshold for that quality level, all the cases are pulled and referred to three physician reviewers, board certified in the same specialty as the treating physician. At least two of the three specialty physicians must agree on a decision. Cases that are not reversed by the specialty physicians then enter the appeals process. The attending physician can present his argument personally to the review panel. He has the right to have a lawyer and expert witnesses, if he desires. Subsequent appeal, assuming continued decisions to uphold the initial finding, is to an administrative law judge.

The attending physician must respond to the letters from the PRO concerning quality review in a timely manner, in writing. Recent HCFA directives do not allow the notification to the hospital of quality review cases involving physicians. This means that the administrative staff of the hospital cannot remind and encourage response to the letter. The consequences of nonresponse is the assumption that the physician does not disagree with the quality review decision. The case then goes to the physician file as a quality problem counting toward possible sanction activity. There may also be an impact on hospital reimbursement.

Many medical records fail to meet the criteria of the quality screen due to the lack of documentation. These cases can be cleared by furnishing the necessary information in writing to the PRO when requested. Some complex medical problems may be misunderstood or misinterpreted by the primary and physician reviewer. The attending physician can usually clear the case by furnishing an explanation in writing to the PRO.

The PRO law and regulations require release of some data to the media. The data is considered nonconfidential and relates to institutions, but not physicians or patients. Data cannot be released if it can be used to identify either a specific physician or patient. Hospital administrators are given 30 days to add their comments to data before release to the media. The PRO has no control over the manner in which the media presents the data. The premise behind release of the data is that the consumers (Medicare beneficiaries) will be better able to select the appropriate institution for their needs.

This very superficial summary of PRO activity omits the detailed review requirements and time constraints. That information can be obtained from your hospital administrative staff or the PRO. The interpretation and dissemination of information related to peer review to the physician and nursing staff of the hospital by the hospital administrative staff is very important. It is the physician's responsibility to gain education and information concerning PRO activity, and, hopefully, participate as a reviewer, in order to protect the integrity of the current system of medical care. The PRO, like the IRS, may not be very pleasant, but it is operating under existing law and will be here for years to come. ■


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# Reflections of Tomorrow

## *or*

## *The Night of the Catcus By Doctor Charlie and Ray*

**Jim Lowry**

RAY: "Margarita, please, Miss."

*Doctor Charlie:* "Hi, Ray, what you drinking?"

*Ray:* "Hey, Doctor Charlie! I'm having a margarita."

*Doctor Charlie:* "Miss, make that two, please. So, Ray, how's the world treating administrators these days?"

*Ray:* "A little better than Oliver North, Doctor Charlie."

*Doctor Charlie:* "I just came from a health care planning meeting, Ray, and I tell you, health care has really changed in the last decade. DRGs, PROs, PPOs, HMOs, CONs, UR, QA, Market Share. Do you think health care is going to be more complicated in the future?"

*Ray:* "No, Doctor Charlie, I think health care will probably be simpler."

*Doctor Charlie:* "Simpler?"

*Ray:* "Yes. I believe we'll fumble around for the next 10 years with all types of DRGs, CONs, HMOs and traditional systems. Can you really imagine anyone designing a system like we have today for the patients of tomorrow?"

*Doctor Charlie:* "What do you mean?

*Ray:* "Do you believe if you had to create a new health care system that you would create one like we have today? What we have today is an environment created for the benefit of the health care providers.

"Can you imagine a patient going to one hospital, staying 7 days, and receiving nine different bills from nine different health care corporations? Can you imagine someone designing a $50 million a year business with one product to sell and having to rely on a 150 different independent health care providers to deliver that product? Can you imagine someone establishing a large business and taking legal responsibility for that business, but delegating that product to a 150 different health care corporations that have ultimate control on how that product is designed and received by the customer? No one would design a system that way on purpose!"

*Doctor Charlie:* "Ray, what would you change if you could start from scratch?"

*Ray:* "First, the successful Health Care System of the future will put the patient first — in quality, convenience, and human relations. To do this, the Health Care System will be comprised of three major corporations: the medical staff corporation, the hospital corporation, and the trustee board.

"The physicians that affiliate with a Health Care System will all be members of the medical staff corporation. This corporation will bill for all physician services and reimburse each physician based upon some type of internal formula of their own choosing. This organization will be organized with a chief executive officer, who will be a physician.

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He will be responsible for the organizing, managing, and delegating of the corporation. He will employ the designated physicians that will manage the related health care department. This mangement team, with input from other physicians, will be responsible for designing the health care product, setting all policies, procedures, and clinical standards, and monitoring the results so that the health care product is competitive and meets the expectations of the physician corporation, the patient, and the trustees."

*Doctor Charlie:* "Two more margaritas, please, Miss."

*Ray:* "This type of physician corporation has two controversial points. First, the senior physician management team establishes all clinical procedures, policies, and quality assurance. The clinical individuality is significantly reduced, leaving the practicing physicians such major assets as convenience to the patient, human resource skills of communication and listening, and diagnostic and technical skills. Secondly, the method of compensation would be similar to that for PhDs who work for major corporations. Compensation would be tied more to responsibility and supervision than to individual output. There will be two types of participating physicians that will associate with the medical staff corporation — the corporate physician and the contract physician.

"The corporate physician will have two levels, that of the staff physician and the clinical physician. The staff physician will work exclusively in the hospital environment assigned to designated areas, such as ER, OB, Intensive Care, and OR. These physicians will provide emergency services and assistance to the clinical physicians assigned to the corporation. The clinical physicians will have the traditional physician role. They will work mainly in a group environment. They will assess the patient's needs, admit the patient to the hospital, and receive the benefit of the staff physician for night and emergency back up. The clinical physicians will be supervised and monitored through quality assurance standards by the senior physician management team.

"Contract physicians will be independent practitioners that have been approved by the medical staff corporation to bring their patients to the hospital. All billing will be done for their services through the medical staff corporation, and the contract physician will receive a percentage of the bill. They will be required to follow the same clinical procedures and quality assurance standards, and they will receive the services of the staff physicians when their patients pass through the designated areas. Emergency back up and assistance at night will be available through the staff physicians."

*Doctor Charlie:* "Ray, what about the technical side, the hospital side?"

*Ray:* "The hospital side won't change much. Hospitals have always been built and designed to support and compliment the physician's practice. Once the physicians become organized and start acting as one unit, then the mission of the System will become clear. The problem we have now is that we have 150 doctors with 150 different missions. With this environment, trustees are hiring strong willed and aggressive administrators to protect the mission of the hospital, which is to survive and provide a quality health care product 'forever' for the patients in the service area. Many trustees feel uncomfortable that doctors, in an effort to gain financial reward, may jeopardize the financial stability of the hospital, which they see as a community asset."

*Doctor Charlie:* "Two more margaritas, please."

*Ray:* "This leads us to the trustees, Doctor. All health care systems of the future will have a lay trustee board as supreme authority over the system, whether the hospital is a for profit or a not-for-profit entity. To assure the hospital trustees will always have supreme authority, the provider numbers for the hospital's technical reimbursement and the physician's reimbursement will be issued in the board's name. The function of the trustees in the future will be the same as they are today.

1. To assure survival of the Health Care System for the community.
2. To assure quality of the health care product.
3. To see that the health care services are reasonably priced for the community.

"As you can see, the role of the trustees will become less controversial once they are assured that the strategic planning process of the medical staff corporation supports the health care mission of the community. Quality Assurance will be delegated to the medical staff corporation, leaving only approval of the budgetary process of the hospital and the medical staff corporation as their main task."

"Well, Doctor Charlie, what do you think? Doctor? Doctor! Miss! A pot of coffee, please!" ■

# The PRO Wants You!

*Richard Greene*

***"This article outlines the PRO process and provides cautions for physicians to heed if they become involved in a PRO review."***

As the size of the Medicare budget has steadily grown, so have the demands of the federal government for accountability. The latest onslaught of federal intervention into the practice of medicine comes from Medicare Peer Review Organization's (PROs) Quality of Care Review Procedures. By design, these review procedures are aimed at sanctioning physicians and providers for anything they consider to be less than adequate quality of care.

In Georgia, the Health Care Financing Administration (HCFA) has contracted with the Georgia Medical Care Foundation (GMCF) as the Peer Review Organization to provide medical review for Medicare beneficiaries. They are required under their contract to assure that the services ordered by a physician or delivered by a provider:

(1) will be provided economically and only when, and to the extent, medically necessary;

(2) will be of a quality which meets professionally recognized standards of health care; and

(3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

There has been considerable adverse reaction from the physician and provider communities all across the country to the PROs attempts to address the above concerns. The situation in Georgia is no exception. The problems in our state have been increased because of a severe backlog of required PRO reviews. The backlog is the result of the GMCF's having temporally lost its PRO contract with HCFA. GMCF eventually was re-awarded the contract, but the time lag created considerable trouble for them and for the physicians in our state.

The GMCF PRO activities alone with account for approximately 84,000 reviews per year based on 30% of 280,000 hospital admissions. They have experienced considerable internal "oversights" or errors made by them as they have attempted to review 18 months of admissions in less than 12 months. Many doctors are receiving inappropriate "Quality Review Notification" letters due in part to this backlog.

These numerous inappropriate Quality Review Notification letters have created significant miscontent with physicians throughout Georgia. This article will attempt to outline the PRO process and provide cautions for physicians to heed if they become involved in a PRO review.

GMCF is also heavily involved in pre-admission and dismissal screenings, another HCFA activity. Physicians often become frustrated with the process and tell the patient that "there's nothing I can do." A word of caution is important. . . . Your role as the physicians is to provide the best possible necessary medical care. If you feel that it is medically appropriate for your patie to be admitted or not to be dismisse from the hospital despite a GMCF objection, then you have the responsibility to become an advocat for your patient. Your refusal to challenge and adverse opinion you consider to be wrong may make you liable for damages to the patient. Ge the department chairman or chief-of staff to review the records to confirm your position. The worst action is inaction.

Physicians, hospitals, hospital medical staffs, etc. are urged to

*Mr. Greene is MAG's General Counsel.*

vigorously appeal any adverse decision that is felt to be incorrect. Many discharge, pre-screening, admission, denials and quality determinations are being won on appeal. There is an internal appeal process with the PRO that should be used to the fullest. The experience in many states is that well over 50% of the adverse decisions are being overturned on appeal.

The PRO process begins with a nurse or other GMCF employee with some medical records experience randomly reviewing medical records at a hospital. The GMCF employee in theory should be a nurse, but in reality often times is not that highly trained because of a shortage of nurses or economic restraints. This employee proceeds to apply a "generic screen" to each review record. This is sometimes referred to as "cookbook medicine." This generic screen concerns the three major areas of intensity of service, severity of illness, and discharge screening. Essentially, these criteria describe medical necessity for each care where objective evidence is present in the medical record. There are component screens for all adult and pediatric patients as well as specific diagnosis screens for cardiovascular, gastrointestinal tract and abdomen, musculosketal/spine, psychiatric, etc. The generic screen will look for specific laundry list components such as temperature of 102° or higher, acute loss of ability to move a body part, sudden decrease in urinary output, etc. The generic reviewer, by applying the laundry list, will make a preliminary determination of whether inappropriate medical care has been provided. The complete medical record will then be copied and sent to a Physician Advisor for review. This person must be a licensed M.D. Before any letter is sent to a physician, another M.D. has to personally review the file and concur that the record indicates that it may result in an adverse determination.

It is at the generic screening and Physician Advisor review level that the system is presently experiencing its greatest difficulties in Georgia. Too many inappropriate Quality Review Notification letters are being sent to Medicare-participating physicians, MAG has received numerous complaints and examples of ridiculous notifications. One MAG member got two letters on one patient's single hospitalization, first claiming that the admissions was inappropriate because the patient was not sick enough. A second letter followed several days later claiming that the patient was too sick to have been discharged.

Part of the problem is created by the system itself. A Physician Reviewer is expected to properly review 10 to 20 complete hospitalization medical records per hour for which he is paid $50 to $60. If a physician is attracted to the program for the income, then the system is attracting the wrong kind of physicians. We are encouraging MAG members to offer their services as reviewers to GMCF. If we in organized medicine want the PRO process to improve, then our direct participation is necessary. About one dozen doctors are now conducting approximately one third of the 84,000 reviews. The PRO may *want* to sanction you, but right now the *need* your help. Better reviewers equates to better reviews.

***"The physician response (to a quality notification letter) should not be caustic, insulting, or lack a serious response. Suggestions as to actions the PRO employees can administer to themselves are not appropriate."***

The New Jersey Medical Board has issued a finding that the review of a medical record by a physician constitutes the practice of medicine. Therefore, if the Physician Reviewer is negligent in not properly reviewing the physician's file, then the reviewer's license to practice medicine is subject to Board sanctions. This approach by New Jersey is novel, but appears to have lead to the decrease in the New Jersey PRO's error rate. Perhaps the Composite Board of Medical Examiners in Georgia will consider similar action if the GMCF error rate continues at unacceptable levels.

***"We are encouraging MAG members to offer their services as reviewers to GMCF. If we in organized medicine want the PRO process to improve, then our direct participation is necessary."***

I must hasten to add that the atmosphere between organized medicine and the PRO is extremely adversarial. The New Jersey PRO is a private contractor with no relationship to the state medical society. A recent meeting of state medical society General Counsels made it very clear that the problems were much less in states like Georgia where there was long established working relationship with the PRO. It is important that this relationship of cooperation continue.

The review procedure established by GMCF is one of the best and fairest in the country. It provides for physicians (rather than staff) reviewers at virtually every level before any adverse action is taken against a physician. Once a doctor receives a quality notification letter, he should immediately respond in writing. He should also immediately ask a peer review mechanism within his hospital or county medial society to also review the record. If they agree with the physician that appropriate care was provided, then a report should be forwarded to GMCF. The physician's individual response should be clear, to the point, and sufficiently extensive to document his contention. The physician response should not be caustic, insulting, or lack a serious response. Suggestions as to actions the PRO employees can administer to themselves are not appropriate.

Many physicians have become so incensed at what they perceive to be an inappropriate initial notification letter that some have tended to ignore it. You must respond or subject yourself to possible sanctions. The PRO process can unexpectedly and rapidly progress to a more serious level before you realize it.

The physician's response to the notification must be completed within 10 days of receipt of the notice. This provides little time to react. The PRO then assigns a different physician to review the record, plus the new documentation and/or explanation. If this reviewer agrees with the physician, then the matter is dropped. If it goes beyond this stage, it is rapidly becoming serious. No physician should proceed beyond this point without legal representation. If you are concerned that there may be an adverse ruling, then you should retain legal counsel at the earliest level.

There are a number of different sanctions that can be imposed by the PRO, ranging from required retraining and educational courses, termination from Medicare participation for a set time or permanently, and monetary sanction equivalent to the cost of the inappropriate or unnecessary medical care. These sanctions are in addition to other penalties through civil or criminal or licensure actions.

The sanction process may be invoked if the PRO determines that the physician has either (1) "failed substantially to comply with any obligation in a substantial number of cases;" or (2) "grossly and flagrantly violated any obligation in one or more instances." Under new guidelines forced upon HCFA by an AMA lawsuit, the physician now has a right to a full hearing complete with the right to legal counsel and the right to present expert testimony in support of his position. If the PRO still rules against the doctor, then the case is forwarded to the Office of Inspector General where additional testimony can be provided. Eventually, an adverse ruling can be taken into a court of law. However, this is extremely expensive and usually can be avoided by a proper response at the initial notice level.

***"MAG is also very interested in developing a 'clearing house' of information and complaints from our members who have been reviewed by GMCF."***

The MAG Ad Hoc Committee on PRO Review prepared an excellent report on and explanation of the PRO review process. This report was submitted to the MAG House of Delegates in April, 1987. If you are interested in a copy, please contact me at MAG headquarters.

MAG is also very interested in developing a "clearinghouse" of information and complaints from our members who have been reviewed by GMCF. Please forward copies of GMCF letters and your response to me at MAG headquarters. This will greatly assist us as we attempt to assist you. Please delete the names or other identifiers of patients to protect confidentiality.■

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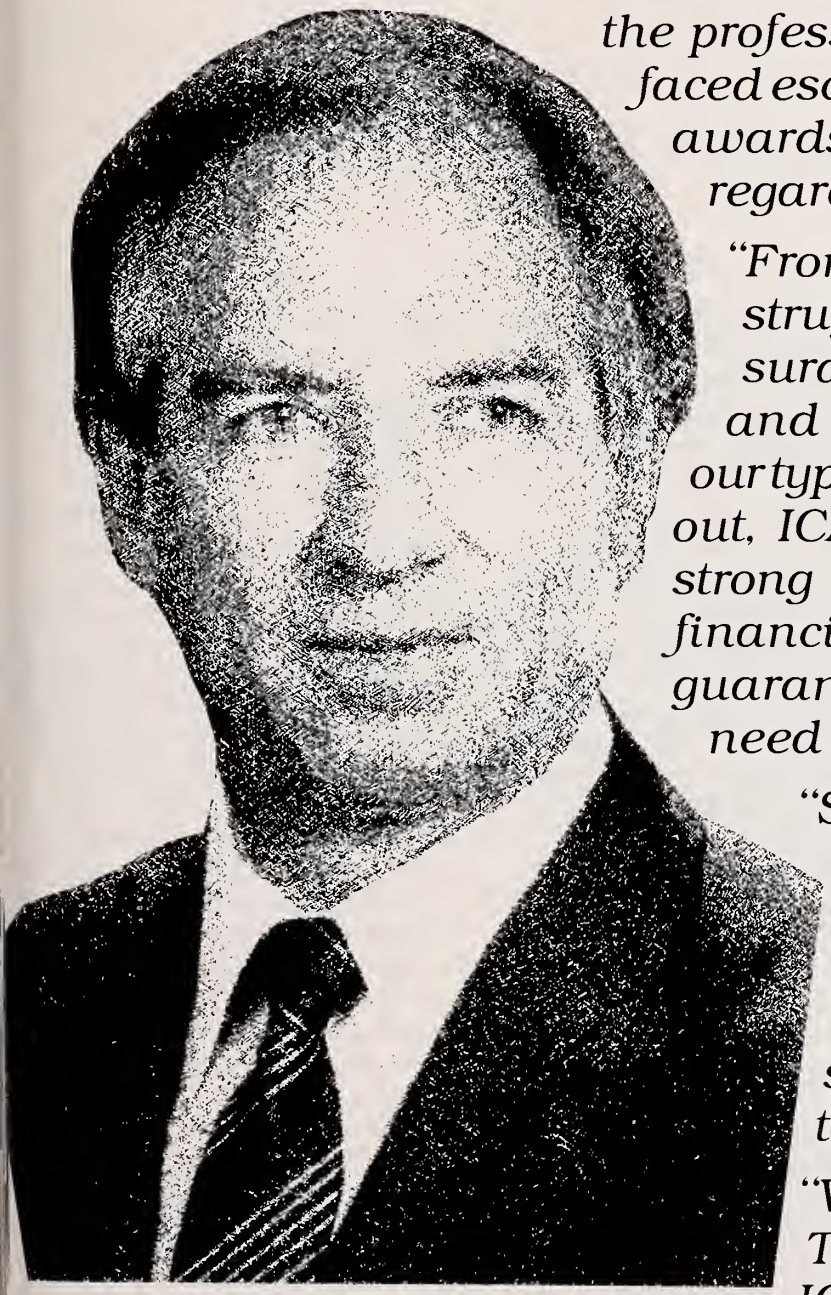

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# Abstracts from Symposium on Cardiovascular Research: Part II

*On August 8, 1986, the Georgia Affiliate of the American Heart Association held a symposium on Cardiovascular Research. More than 80 physicians and scientists from across the state gathered at the University of Georgia in Athens to present findings of research supported in part by contributions of Georgia residents. The following abstracts are representative of the research investigations discussed at this symposium and is the second of three parts to be presented in the HEART Section.*

## THE INFLUENCE OF VASODILATORS ON HUMAN MAMMARY ARTERY SPASM.

*G. Kimble Jett, Robert A. Guyton, Charles R. Hatcher, Peter W. Abel. Emory University School of Medicine.*

The internal mammary artery (IMA) is currently the preferred conduit for myocardial revascularization. During isolation of the IMA and its pedicle, spasm of the artery is often seen. Therefore, we investigated the ability of various vasodilators to inhibit IMA contraction utilizing discarded segments of human IMA not used for coronary artery bypass grafting. Ring segments of fifteen arteries were suspended on strain gauges in muscle baths containing 37°C Krebs solution for measurement of isometric tension *in vitro*. Arterial contraction was stimulated with 70mM potassium (K) or 10uM norepinephrine (NE) and inhibition of contraction by vasodilators was measured. The concentration of vasodilator causing 50% inhibition of contraction ($EC_{50}$) was calculated from dose response curves. Potency was determined from the $EC_{50}$ values and were in decreasing order:

| | $EC_{50}$(uM) | | Max. % Inhibition | |
|---|---|---|---|---|
| *Vasodilator* | *K* | *NE* | *K* | *NE* |
| **Nifedipine** | **0.004** | **0.019** | **92±1** | **30±3** |
| **Verapamil** | **0.224** | **4.68** | **91±1** | **75±5** |
| **Nitroprusside** | **0.302** | **0.447** | **55±7** | **71±8** |
| **Papaverine** | **8.32** | **4.07** | **96±3** | **95±3** |

Little or no inhibition of IMA contraction was seen with nitroglycerin, isoproterenol and adenosine. Although nifedipine was the most potent vasodilator, papaverine produced the greatest maximal inhibition of K or NE induced contraction of human IMA.

## VASCULAR REACTIVITY OF ARTERIOSCLEROTIC PULMONARY ARTERIES IN DOGS.

*C. A. Rawlings, M. Kalis, R. Poser, R. L. Tackett. University of Georgia, Athens, GA.*

Vascular responses were studied in dogs with low grade, chronic injury of the pulmonary arteries produced by heartworm infection. Four groups of 8 dogs each were studied with 1 group being noninfected controls, 1 group having a long term naturally contracted heartworm infection, and 2 groups having had heartworms transplanted 4 days (d) and 4 weeks (w), respectively. The 4 w group did not have pulmonary hypertension. SEM revealed endothelial swelling and fenestration, widened endothelial junctions, focal denudation, and adhesion of platelets and leukocytes at 4 d. At 4 w, endothelial like cells covered intimal lesions of multiplying smooth muscle cells.

Vasomotor responses of these damaged arteries were studied in vitro. In contrast to arteries of the control dogs, none of the heartworm infected dogs dilated when exposed to acetylcholine demonstrating a compromised endothelium. The 4 d group had a decreased response to norepinephrine, which may have been due to a lack of differentiation and responsiveness of the rapidly dividing smooth muscle cells. Long term infected dogs had a greater response to histamine than the control arteries, which were more responsive than the 4 d and 4 w arteries. Response to serotonin was unaffected. Histamine may be a mediator of hypertension in dogs with pulmonary arterial injury.

The HEART Section is sponsored by the Georgia Affiliate of the American Heart Association. Those wishing to contribute articles to this Section should send them to Wesley Covitz, M.D., HEART Editor, Section of Pediatric Cardiology, Medical College of Georgia, Augusta, GA 30912.

EFFECT OF PAPAVERINE ON HE DISTRIBUTION OF ULMONARY VASCULAR ESISTANCE AFTER EMBOLISM.

C. Ehrhart and W. F. Hofman, epartment of Physiology, School of edicine, Medical College of eorgia, Augusta, GA 30912.

We have shown that experimentally induced lung nbolism increases pre-capillary sistance thus reducing transmission pulmonary arterial pressure (Pa) to icrovessels. If pre-capillary soconstriction accompanies nbolism, vasodilation at constant Pa ay elevate capillary pressure (Pc) d increase edema. After 100um ass beads were given to the canine t lower lung lobe in situ, the lobe s removed, ventilated and pump-rfused with autogenous blood at Pa 25 Torr. Papaverine, 30-60 mg, s given 1 h post embolism. The stribution of vascular resistance s obtained by venous occlusion d a capillary filtration coefficient f) was obtained gravimetrically as index of permeability easurements did not differ between paverine treated and untreated bolized lobes. A greater volume airway fluid was found in the paverine treated lobes suggesting t papaverine may increase edema embolized lungs. However, the ater edema was not likely due to a her Pc.

ACETYLCHOLINE ACTIVATED CURRENT IN THE ATRIUM OF THE CHICK EMBRYO.

*Tony L. Creazzo, Department of Anatomy, Medical College of Georgia, Augusta, GA 30912.*

In the adult atrium and ventricle there are two voltage dependent background currents that are carried largely by potassium ions. These are termed $I_{K1}$ and $I_{K(ACh)}$. $I_{K1}$ is largely responsible for the resting membrane potential and $I_{K(ACh)}$ causes the membrane to hyperpolarize when activated by stimulation of muscarinic acetylcholine (ACh) receptors. While these currents have been well characterized in the adult heart, little is known about their development. I have been investigating background current in the developing chick heart using the whole-cell recording variant of the patch clamp technique. Freshly dissociated cells from the atrial region of the heart from 3 to 15 days of incubation were prepared enzymatically by treatment with trypsin and collagenase. Experiments were carried out in Hepes buffered Ringers at room temperature. Cells from early ages tended to be round (10-15 um in diameter) and at later ages they were elongated (20-30 um long). By day 15 the ACh activated $I_{K(ACh)}$ appeared well developed. The I-V relationship showed strong inward rectification, reversal at about -85 mV and a maximum outward current of about 40 pA. However, in the absence of ACh the I-V relationship was always linear with a shallow slope. This indicates that even by day 15 $I_{K1}$ was not present. Other currents such as the TTX sensitive fast Na current, the slow inward Ca current, and a time dependent outward current were observed.

NEUROPEPTIDE Y POTENTIATES CONTRACTION AND INHIBITS RELAXATION OF RABBIT CORONARY ARTERIES.

*Chide Han and Peter W. Abel, Emory University School of Medicine, Department of Pharmacology, Atlanta, GA 30322.*

The effects of neuropeptide Y (NPY) on contraction and relaxation of isolated rabbit coronary arteries were studied. NPY alone caused a weak contraction of coronary arteries with a mean EC value of 29 nM. Following exposure of coronary arteries to 30 nM NPY, the potencies of norepinephrine (in the presence of 3 uM timolol) and histamine in causing contraction were increased by 2-fold, with no change in maximal contraction. After half-maximal contraction of coronary arteries with histamine and addition of 30 nM NPY, relaxation produced by norepinephrine (in the presence of 3 uM phentolamine), adenosine and acetylcholine was inhibited. Dose-

response curves for vasodilators were shifted to the right by 10- to 22-fold. Maximal relaxation caused by adenosine and norepinephrine was not changed by NPY while the maximal response to acetylcholine was 37% less in the presence of NPY. Correlation of the tension produced by NPY with the shift in agonist contraction or relaxation dose-response curves indicated that NPY-induced increases in baseline tone had no effect on the degree of shift in agonist dose-response curves. These results show that NPY causes a modest potentiation of agonist-induced relaxation of rabbit coronary arteries.

## ALPHA AND OPIOIDERGIC RECEPTORS — POSSIBLE SITES OF ACTION OF ANTIHYPERTENSIVE DRUGS.

*R. Tackett, L. Fuchs, and R. Laskey, College of Pharmacy, University of Georgia, Athens, Georgia.*

Opioidergic systems have been implicated in the central control of blood pressure and thus may serve as a site of action of antihypertensive drugs. This mechanism has been evaluated in our laboratory with several antihypertensive drugs. Central administration of BHT 933, a specific $alpha_2$ antagonist, decreased blood pressure and heart rate in pentobarbital anesthetized dogs. Concomitant with the hypotensive response, an increase in CSF β endorphin levels were observed. Pretreatment with naloxone blocked the hypotensive effect but not the decrease in heart rate. Propranolol as well as several other β blocking drugs, has been shown to decrease blood pressure through an interaction with central $alpha_2$ receptors. Pretreatment with naloxone also was shown to effectively block the hypotension but not the drug induced bradycardia. When assessed in WKY and SHR, the hypotensive actions of propranolol, atenolol and practolol were effectively antagonized by naloxone or yohimbine pretreatment. Collectively, these results support an interaction between $alpha_2$ and opioidergic systems in the control of blood pressure. Furthermore, these mechanisms appear to be functional in the normo- and hypertensive state.

## ADRENERGIC MECHANISMS INVOLVED IN ENHANCED VENOUS GRAFT REACTIVITY.

*R. L. Tackett, R. Laskey, and C. A. Rawlings, College of Pharmacy, University of Georgia, Athens, GA.*

The use of vascular bypass grafts represents a major development in the treatment of coronary artery disease. Much of the work associated with vascular grafts has focused on morphological changes which occur during arterialization. However, the present study evaluated vascular reactivity in grafted saphenous veins at 1 week and 6 months post surgery. A segment of saphenous vein was interposed end-to-end into a carotid artery in dogs. Grafts were harvested at the appropriate time, cut into rings and suspended in tissue baths containing Krebs-Henseleit solution. Dose response curves to norepinephrine, acetylcholine, histamine and tyramine were evaluated. All grafts exhibited responses to acetylcholine indicating the presence of functional endothelium. At one week, grafted vessels demonstrated a leftward shift of the norepinephrine curve and automaticity. Those vascular rings which were initially quiescent developed automaticity when exposed to tyramine or norepinephrine. At 6 months, grafted vessels showed a 4 fold increase in weight and a leftward shift in the dose response curves to norepinephrine and histamine. At both 1 week and 6 months, maximal responses to norepinephrine and histamine were increased. These results suggest that significant biochemical changes occur during arterialization in addition to the morphological changes observed by others.

## NON-ADRENERGIC CORONARY VASOCONSTRICTION DUE TO CAROTID SINUS REFLEX.

*R. K. Stack and R. E. Patterson, Department of Medicine, Carlyle Fraser Heart Center, Crawford Lo Hospital of Emory University, Atlanta, GA 30308.*

Brief periods of bilateral carotid occlusion (BCO) cause coronary vasoconstriction after beta blockade. Since coronary synpatheti nerves contain a vasoconstrictor peptide with slow onset of action, v tested the hypothesis that a 5 minut BCO could cause nonadrenergic coronary vasoconstriction. Mean aortic pressure (AOP) and mean lef circumflex coronary blood flow (CBF) were recorded in 6 chloralos anesthetized, open-chest, vagotomized beta blocked (3 mg/kg IV, propranolol + 0.5 mg/kg/hr) dogs. Regional circumflex alpha blockade was achieved with 0.75 m kg intracoronary phenoxybenzamine Coronary vascular resistance (CVR) was calculated as AOP/CBF during and after 5 minute BCO or 5 minut IV norepinephrine (NE) infusion, titrated to equal the change in AOP during BCO. CVR increased 2 minutes after BCO began and persisted 5 minutes after BCO release. NE caused no change in CVR, and AOP returned to control minutes after the infusion. Controls (C) and maximum delta (Δ) are shown for NE and BCO:

| | NE: C | Δ | BCO: C | Δ |
|---|---|---|---|---|
| AOP(mmHg) | 95 | ±48 | 90 | +47 |
| CBF(ml/min) | 44 | +13 | 40 | − 1 |
| CVR(mmHg/ml/min) | 2.71 | +0.21 | 2.74 | +1.37 |

(* $p<0.05$; ** $p<0.01$ for NE Δ versus BCO Δ

It is unlikely that the increase in CVR after BCO is mediated by NE or autoregulation because an

quipressor dose of NE did not ıcrease CVR after alpha block, and ırgical removal of both stellate anglia markedly attenuated the CVR esponse to BCO. Conclusion: ilateral carotid occlusion for 5 ıinutes causes coronary asoconstriction that is not mediated y adrenergic receptors.

HE ANTIHYPERTENSIVE CTIVITY OF A SELENIUM-ONTAINING ANALOG OF HENYLPROPYLAMINE. *S. H. ollock, H. H. Herman, S. W. May, . C, Fowler, and A. Edwards, lercer University School of harmacy and School of Chemistry, eorgia Institute of Technology, tlanta, GA 30312.*

Previous studies using sulfur analogs of phenylpropylamine emonstrated that these compounds ere excellent substrates for opamine beta-monooxygenase DBM) and possessed significant ntihypertensive activity in pontaneously hypertensive rats SHRs). We have conducted studies determine if *selenium-containing* nalogs possessed similar effects on BM and on blood pressure in HRs. Results of our *in vitro* studies ave shown that phenyl-2-aminoethyl elenide (PAESe) affects DBM by a ıechanism different from the sulfur nalogs. This compound selectively epletes ascorbate, a cofactor for BM, resulting in complete ıhibition of the enzyme. These data uggest that administration to SHRs hould result in an inhibition of ynthesis of norepinephrine (NE) and decrease in pressure. Using nesthetized SHRs, acute dministration of PAESe (I.V.) roduced a dose-related decrease in oth systolic and diastolic pressure. imilar results were obtained when AESe was administered I.P. to onscious, unrestrained SHRs with ıe maximum response occurring ithin the first hour. When PAESe as administered I.P. twice daily for 14 days, we observed a dose-related decrease in both systolic pressure and heart rate. There was also a decrease in body weight which may be attributed to an anorexigenic effect of the drug. Furthermore, the decrease ini pressure correlated with a decrease in levels of NE within cardiac tissue and a decrease in heart weight.

ABNORMAL CARDIAC MUSCARINIC ACTIVITY IN DIABETES. *G. O. Carrier and R. S. Aronstam, Department of Pharmacology and Toxicology, Medical College of Georgia, Augusta, GA 30912.*

Cardiac muscarinic receptor systems in short-term STZ-diabetic rats were studied. Right atria from diabetic rats were supersensitive to the negative chronotropic action of acetylcholine, carbamylcholine, and bethanechol. There was so difference in the negative inotropic action of these agents in left atria. There was no difference in neuronal [$^3$H]choline uptake in right or left atria from STZ-diabetic and age-matched control rats. Acetylcholinesterase (ACHE) activity was significantly reduced in right atria, but there was no difference in ACHE in left atria. The density of [$^3$H]QNB binding sites were less in both right and left atria from diabetic rats. Additionally, the $K_D$ for both the high and low affinity agonist binding sites was increased. These findings indicate that cholinergic supersensitivity in the early stages of diabetes is independent of autonomic neuropathy. Changes in muscarinic receptor coupling to effector mechanisms may underlie cardiac muscarinic supersensitivity.

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# Incidence of Melanoma

*Wong-Ho Chow, Ph.D., Jonathan M. Liff, Ph.D., and Raymond S. Greenberg, M.D., Ph.D.*

**Abstract**

*A review of registrations at the Georgia Center for Cancer Statistics revealed a total of 1,627 new diagnoses of histologically confirmed cutaneous malignant melanoma among white residents of metropolitan Atlanta between January 1, 1975, and December 31, 1984. Of these cancers, 812 (49.9%) occurred in males, and 815 (50.1%) were diagnosed among females. The corresponding average annual age-adjusted incidence rates were 14.8 per 100,000 white males and 11.6 per 100,000 white females. These rates are among the highest ever reported in the United States. The male excess in incidence was confined to persons over 40 years of age. When the data were analyzed by year of diagnosis, a dramatic increase in incidence was found for males between 1978 and 1982, with stabilization thereafter. The rates among females did not reveal a consistent trend over time. The etiologic and diagnostic implications of these data were discussed.*

## Introduction

During 1987, it is anticipated that 25,800 new cases of cutaneous malignant melanoma will be diagnosed in the United States, and 5,800 persons will die from this disease.[1] Between 1975 and 1984, the incidence of malignant melanoma in this country rose 37% among white males and 21% among white females.[2] The dramatic increase in the frequency of this disease is of particular concern in high-risk areas, such as the southern United States.[3]

Dr. Chow and Dr. Liff are Assistant Professors of Community Health, and Dr. Greenberg is an Associate Professor of Community Health, Emory University School of Medicine. Send reprint requests to Dr. Greenberg, Georgia Center for Cancer Statistics, 246 Sycamore St., Ste. 100, Decatur, GA 30030.

Historic data on the incidence of cutaneous melanoma in metropolitan Atlanta have been presented in several monographs.[4-6] The purpose of this report is to provide updated information on the population distribution of cutaneous melanoma in Atlanta.

## Materials and Methods

The present data were collected by the Georgia Center for Cancer Statistics (GCCS), a population-based cancer registry affiliated with the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute. The operation of this registry has been described elsewhere,[7] so only a brief synopsis is provided here.

The GCCS has a staff of trained medical abstractors who visited each nonpsychiatric hospital in and around metropolitan Atlanta (Clayton, Cobb, DeKalb, Fulton, and Gwinnett counties). At each of these 37 hospitals, pathology reports and discharge diagnoses were reviewed to identify all cancer patients. A standard medical record abstract was completed for each eligible patient who resided within the five-county catchment area. The abstract included demographic information, as well as diagnostic data, such as topography, histology, grade, stage, tumor sequence, and the initial course of therapy. Of all melanoma patients, 67.7% were identified through hospital records. An additional 12.1% were ascertained through outpatient clinics, and 8.0% were identified at the offices of physicians.

In addition to case-finding at clinical facilities, the abstractors also visited each of the 15 free-standing pathology laboratories in and around Atlanta. Of all persons with melanoma, 11.8% were detected through free-standing pathology laboratories. Finally, the computerized file of death certificates for the State of Georgia was reviewed quarterly to identify patients that were not registered through the hospitals or laboratories. Only 0.3% of melanoma patients were identified exclusively from death certificates.

For the purposes of the present analysis, eligibility was limited to

/hite residents of metropolitan ıtlanta with a new diagnosis of istologically confirmed cutaneous ıalignant melanoma between anuary 1, 1975, and December 31, 984. This study was confined to /hites because the number of cases mong blacks (fewer than two per ear) was too small to provide a ıeaningful analysis. The study eriod was centered around the 1980 J.S. Census,[8] to allow the most ccurate estimates of the ource population. Melanoma ıcidence rates and standard errors /ere calculated by gender and age nd then summarized by direct age djustment[9] using the 1970 U.S. opulation as the standard. Further escriptive analyses were performed /ith two-way contingency tables and orresponding Pearson chi-square tatistics.[10]

## Results

The distribution of cases by age nd gender is depicted in Table 1. )verall, 1,627 cutaneous melanomas /ere registered, 812 (49.9%) of /hich occurred in males and 815 50.1%) of which were diagnosed mong females. The median ages at iagnosis were 50 years for males nd 45 years for females. The verage annual age-adjusted ıcidence rates were 14.8 per 00,000 white males (95% onfidence limits: 11.4, 18.2) and 1.6 per 100,000 white females 95% confidence limits: 9.1, 14.2).

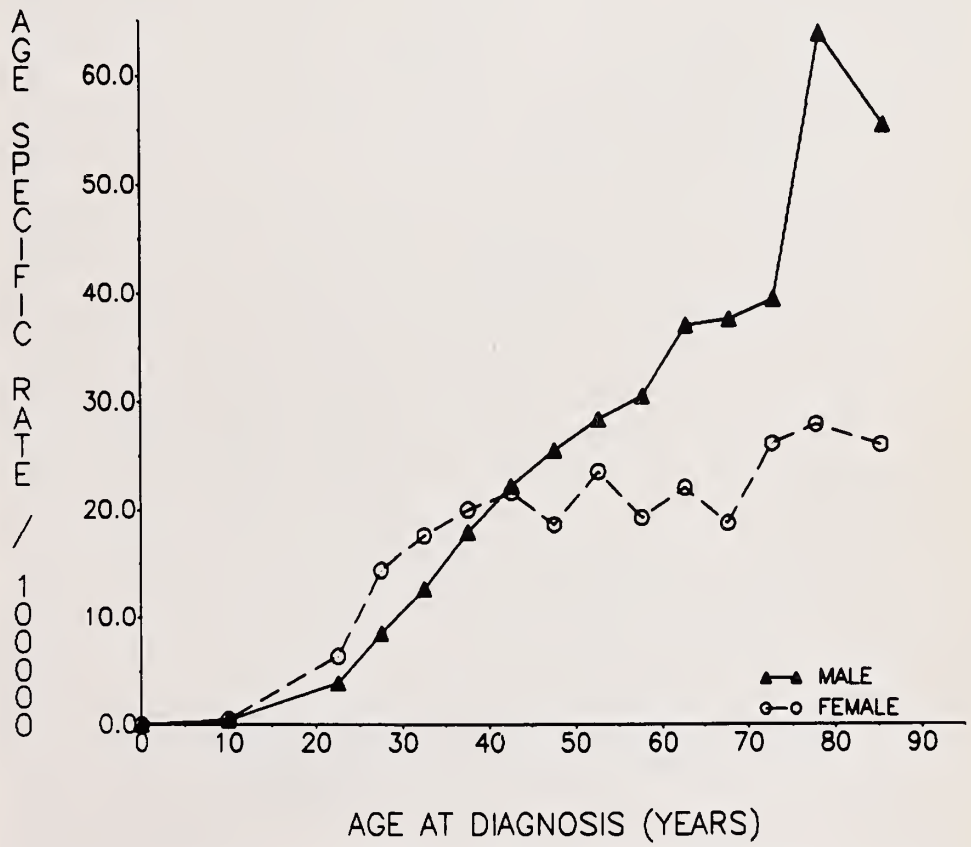


*Figure 1. Age-specific incidence rates for cutaneous melanoma by gender, Atlanta, 1975-84.*

The age-specific incidence rates are presented separately for males and females in Figure 1. For both genders, the incidence climbed from very low levels in childhood to moderately high rates by the fourth decade of life. At older ages, the rates reached a plateau for females, but continued to increase for males. Thus, the excess risk of melanomas among males was confined to ages above 40 years.

The age-adjusted incidence rates are presented by calendar year in

TABLE 1 — Distribution of patients by age and gender*

| Age (years) | Males n | Males (%) | Females n | Females (%) |
|---|---|---|---|---|
| ≤ 29 | 79 | ( 9.7) | 131 | (16.1) |
| 30-39 | 158 | (19.5) | 203 | (24.9) |
| 40-49 | 166 | (20.4) | 142 | (17.4) |
| 50-59 | 173 | (21.3) | 136 | (16.7) |
| 60-69 | 131 | (16.1) | 89 | (10.9) |
| 70-79 | 77 | ( 9.5) | 77 | ( 9.4) |
| ≥ 80 | 28 | ( 3.4) | 37 | ( 4.5) |
| Total | 812 | (100) | 815 | (100) |

* Chi-square with six d.f. = 34, p < .00001.

TABLE 2 — Distribution of lesions by primary anatomic site and gender*

| Anatomic Site | Males n | Males (%) | Females n | Females (%) |
|---|---|---|---|---|
| Head and neck | 166 | (20.4) | 108 | (13.3) |
| Chest, back, shoulders | 321 | (39.5) | 197 | (24.2) |
| Arms and hands | 172 | (21.2) | 247 | (30.3) |
| Legs and feet | 92 | (11.3) | 235 | (28.8) |
| Other sites | 61 | ( 7.5) | 28 | ( 3.4) |
| Total | 812 | (100) | 815 | (100) |

* Chi-square with four d.f. = 130, p < .00001.

TABLE 3 — Distribution of ages at diagnosis for patients with selected histologic growth patterns*

| Age (years) | Superficial spreading n | Superficial spreading (%) | Nodular n | Nodular (%) | Lentigo maligna n | Lentigo maligna (%) |
|---|---|---|---|---|---|---|
| ≤ 29 | 108 | (14.6) | 12 | ( 8.7) | 0 | ( .0) |
| 30-39 | 202 | (27.2) | 29 | (21.0) | 6 | ( 5.8) |
| 40-49 | 153 | (20.6) | 21 | (15.2) | 11 | (10.7) |
| 50-59 | 135 | (18.2) | 26 | (18.8) | 20 | (19.4) |
| 60-69 | 86 | (11.6) | 24 | (17.4) | 23 | (22.3) |
| 70-79 | 45 | ( 6.1) | 17 | (12.3) | 27 | (26.2) |
| ≥ 80 | 13 | ( 1.8) | 9 | ( 6.5) | 16 | (15.5) |
| Total | 742 | (100) | 138 | (100) | 103 | (100) |

* Chi-square with 12 d.f. = 140, p < .00001.

Figure 2. The rates among males rose about 50% between 1978 and 1982 and stabilized thereafter. For females, there was a less consistent trend, although there was a suggestion of an overall increase.

The distribution of lesions by primary anatomic site and gender is shown in Table 2. These data revealed a stronger predilection for locations on the head and trunk among males and on the extremities among females.

Analysis by histologic type was limited by the large percentage of lesions with unspecified growth patterns (37.1%). Of the melanomas with specified histologic types, a superficial spreading pattern was the most common (72.5%), followed by nodular lesions (13.5%), lentigo maligna melanoma (10.1%), and others (4.0%). The distribution of histologic patterns was found to vary with primary anatomic location: 59.2% of lentigo maligna melanomas occurred on the head and neck, compared with only 12.3% of superficial spreading lesions. The most common site of origin for superficial spreading tumors was the trunk (35.7%), whereas only 5.8% of lentigo maligna melanomas arose at that site.

The distribution of selected histologic types by age at diagnosis is depicted in Table 3. It is clear from these data that superficial spreading lesions tended to occur among relatively young adults (median age = 44 years), nodular melanomas were found among slightly older persons (median age = 53 years), and lentigo maligna melanomas were diagnosed among the elderly (median age = 66 years).

Overall, 92.4% of patients were classified according to the stage at diagnosis. Of the patients with

own stage, 92.2% had disease :alized to the site of origin, 5.1% d regional extension and 2.7% had stant metastases. In general, the oportion of patients with metastatic sease increased with advancing age g., age 30-39, 0.9%; age 70-79, 1%). The proportion of unstaged ses also tended to be higher among : elderly, presumably related to s aggressive diagnostic evaluation d treatment of older persons. though lentigo maligna melanomas ided to occur among the elderly, .2% of such lesions were localized diagnosis. A similarly high rcentage of superficial spreading elanomas (93.4%) were confined to : site of origin. In contrast, nodular elanomas and those with specified growth patterns were less ely to be localized at diagnosis; .3% and 75.3%, respectively.

## Discussion

The incidence rates for cutaneous elanoma observed in this study are ong the highest ever reported in : United States. The average nual age-adjusted incidence for ite males in Atlanta was 57% gher than a recent estimate for all :ER areas combined, and the erage annual age-adjusted :idence for white females in lanta was 43% higher than the tional rate.[6] Others have postulated it the comparatively high rates of elanoma in the southern United ites may be a consequence of cessive exposure to solar liation.[3, 11]

The higher age-adjusted incidence es for male Atlantans compared to nale Atlantans is consistent with : national experience.[2, 4-6] kewise, the age-specific patterns of mbing incidence rates above 40 ong males, contrasted with uniform rates in older women, have been observed in national statistics.[5, 6] The gender differential in anatomic location of melanomas has been noted elsewhere[12, 13] and generally follows the patterns of body surface protection by clothing. The differences in ages at diagnosis for different subtypes of melanoma probably are related to the growth characteristics of these cancers and also may derive from different modes of causation.

The pattern of increase in age-adjusted incidence rates of melanoma among male Atlantans since 1975 was very similar to that for all SEER registries combined[2] and may represent a continuation of a previously observed increase over time.[14] The reasons for this increase are unknown. The observations of

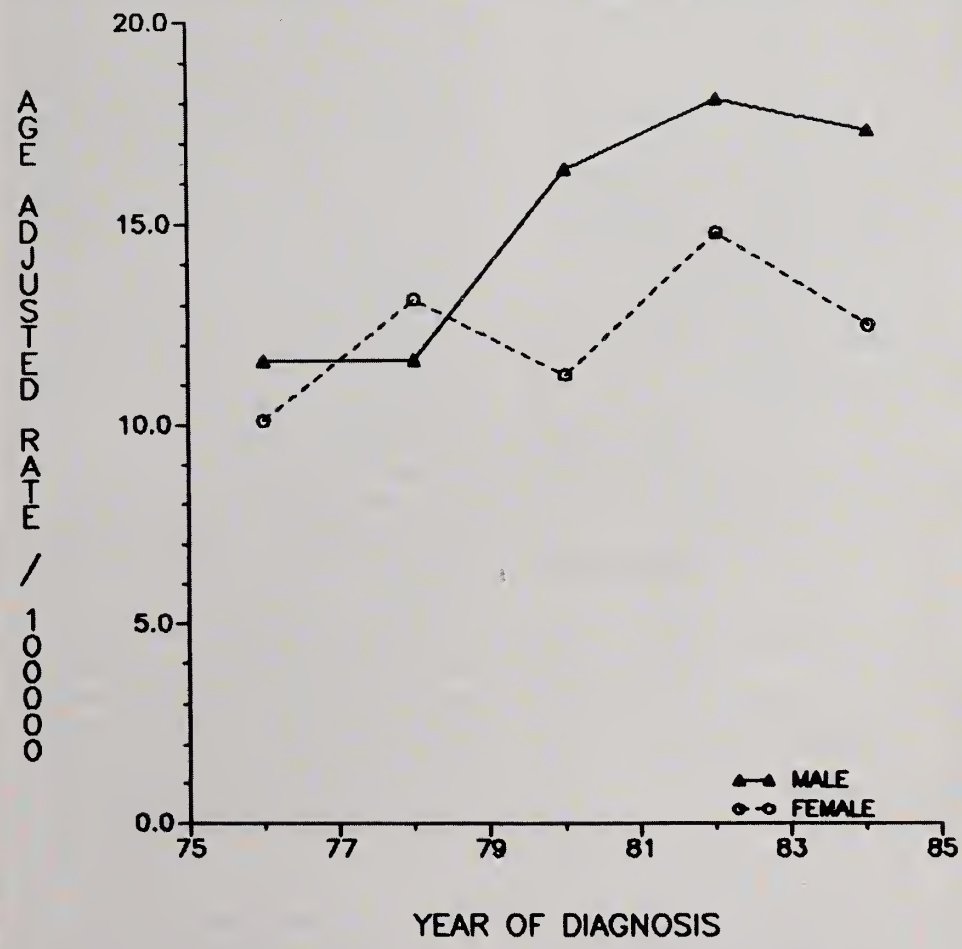


*Figure 2. Age-adjusted incidence rates for cutaneous melanoma by gender, Atlanta, 1975-84.*

concurrent increasing rates of non-melanoma skin cancers, and the absence of such increases in ocular melanomas have been offered as evidence for a role of ultraviolet light in the melanoma increase.[11] Therefore, suggested explanations have included changes in sun exposure practices of the population and the recent use of skin tanning devices.[11, 15-18] Other lifestyle factors that may modify the effect of ultraviolet radiation or operate through some other mechanism[11, 19] have been considered.

***"The dramatic increase in the frequency of this disease is of particular concern in high-risk areas, such as the southern United States."***

It is possible that the observed plateau in incidence after 1980 is an artifact related to the failure of the registry to identify patients who were diagnosed and managed exclusively as outpatients. A telephone survey of dermatologists in the Atlanta area, however, failed to demonstrate any recent changes in obtaining and referring pathologic specimens for review. If the recent plateau in incidence rates is not an artifact, it may reflect a beneficial effect of sunscreens which have come into widespread use during the past decade, or a modification in some other behavior related to sun exposure.

The prognosis for patients with cutaneous melanoma clearly is related to stage at diagnosis. Recent analysis of data on persons with malignant melanoma from the SEER Program[2] yielded the following stage-specific 5-year relative survival rates: localized, 89%; regional, 56%; distant, 14%. Thus, early recognition of disease is essential for the control of morbidity and mortality from melanoma. Toward this end, physicians should perform skin examinations on their patients, and encourage patients to practice regular skin self-examination.[20]

In addition, while the exact reasons for temporal changes in cutaneous melanoma rates have not been established, the relationship of intensive sun exposure to increased risk of this disease is well established. Therefore, to diminish the risk of melanotic, as well as non-melanotic, skin cancers, it is prudent for physicians to counsel patients to avoid traumatic sun exposure and to encourage the use of sunscreen products by children and adults.[21-23]

## Acknowledgments

This work was supported by contract NO1-CN-55429 from the National Cancer Institute. The authors thank the physicians and hospitals who provided information on patients with melanoma. Appreciation is also extended to the staff who collected, coded, edited, and processed these data, and to Ms. Pauline Storey who assisted in the preparation of this manuscript.

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Insurance Corporation of America ..... 581

Lilly, Eli & Company ..... 560B

MAG Mutual Insurance Company ..... 536

M$NY Credit Corporation ..... 568

Roche Laboratories ..... 544A-D, 593, 594

Smith, Kline & French Laboratories ..... 552A

Upjohn Company ..... 560A

U.S. Air Force ..... 568

U.S. Navy ..... 564

Weight Watchers of Greater Atlanta ..... 538

Woodridge Hospital ..... 575


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**INDERAL® LA** brand of propranolol hydrochloride **(Long Acting Capsules)**

**DESCRIPTION.** INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

**CLINICAL PHARMACOLOGY.** INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

**INDICATIONS AND USAGE. Hypertension:** INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

**Angina Pectoris Due to Coronary Atherosclerosis:** INDERAL LA is indicated for the long-term management of patients with angina pectoris.

**Migraine:** INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

**Hypertrophic Subaortic Stenosis:** INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

**CONTRAINDICATIONS.** INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first-degree block, 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

**WARNINGS.** CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

**Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)**—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing $T_4$ and reverse $T_3$, and decreasing $T_3$.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

**PRECAUTIONS.** GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

*Aluminum hydroxide gel* greatly reduces intestinal absorption of propranolol.

*Ethanol* slows the rate of absorption of propranolol.

*Phenytoin, phenobarbitone,* and *rifampin* accelerate propranolol clearance.

*Chlorpromazine,* when used concomitantly with propranolol, results in increased plasma levels of both drugs.

*Antipyrine* and *lidocaine* have reduced clearance when used concomitantly with propranolol.

*Thyroxine* may result in a lower than expected $T_3$ concentration when used concomitantly with propranolol.

*Cimetidine* decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

*Theophylline* clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS.** Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

*Cardiovascular:* Bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

*Central Nervous System:* Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

*Gastrointestinal:* Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

*Allergic:* Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

*Respiratory:* Bronchospasm.

*Hematologic:* Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

*Auto-Immune:* In extremely rare instances, systemic lupus erythematosus has been reported.

*Miscellaneous:* Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

**DOSAGE AND ADMINISTRATION.** INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

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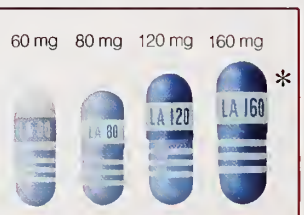


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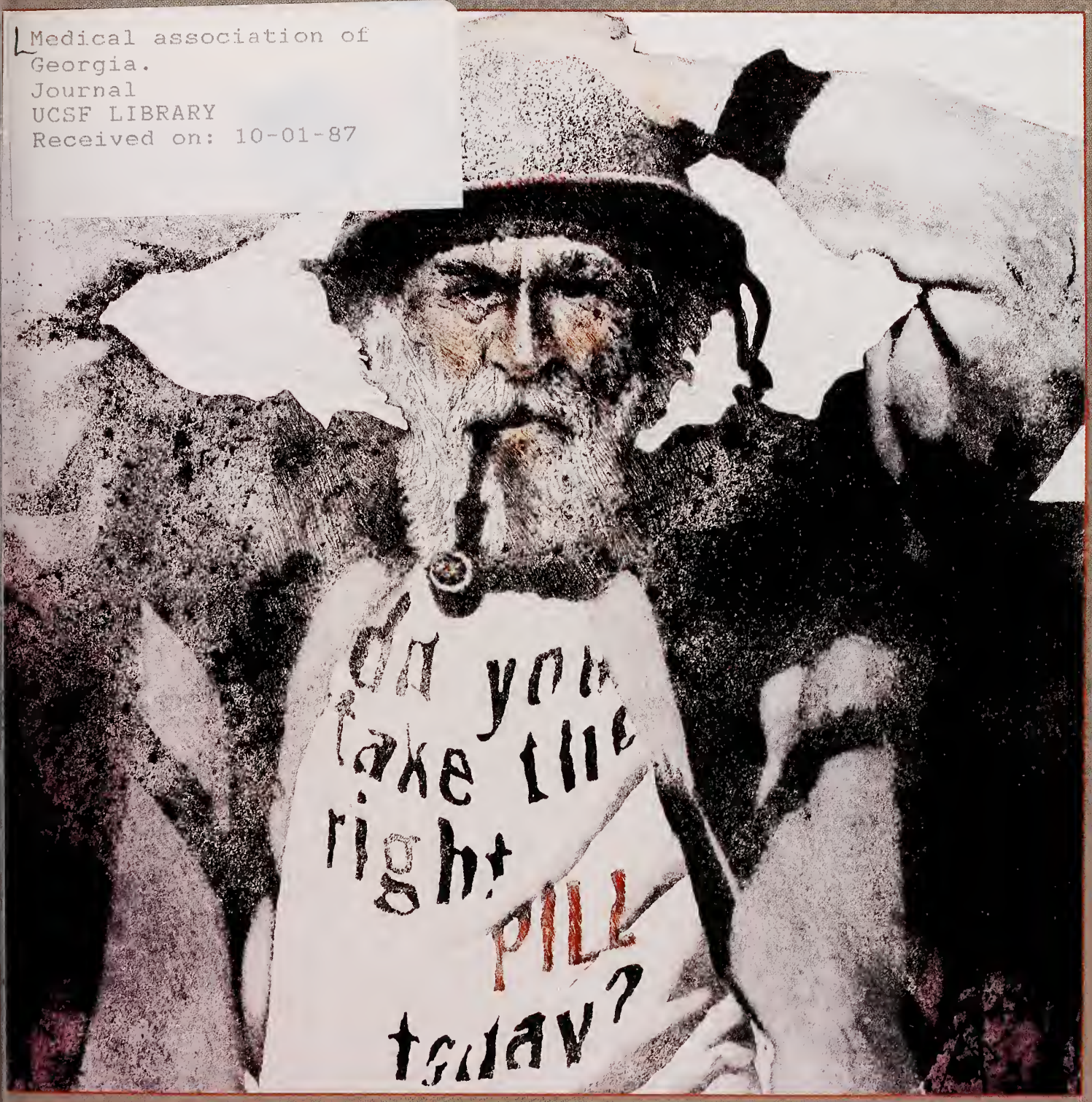


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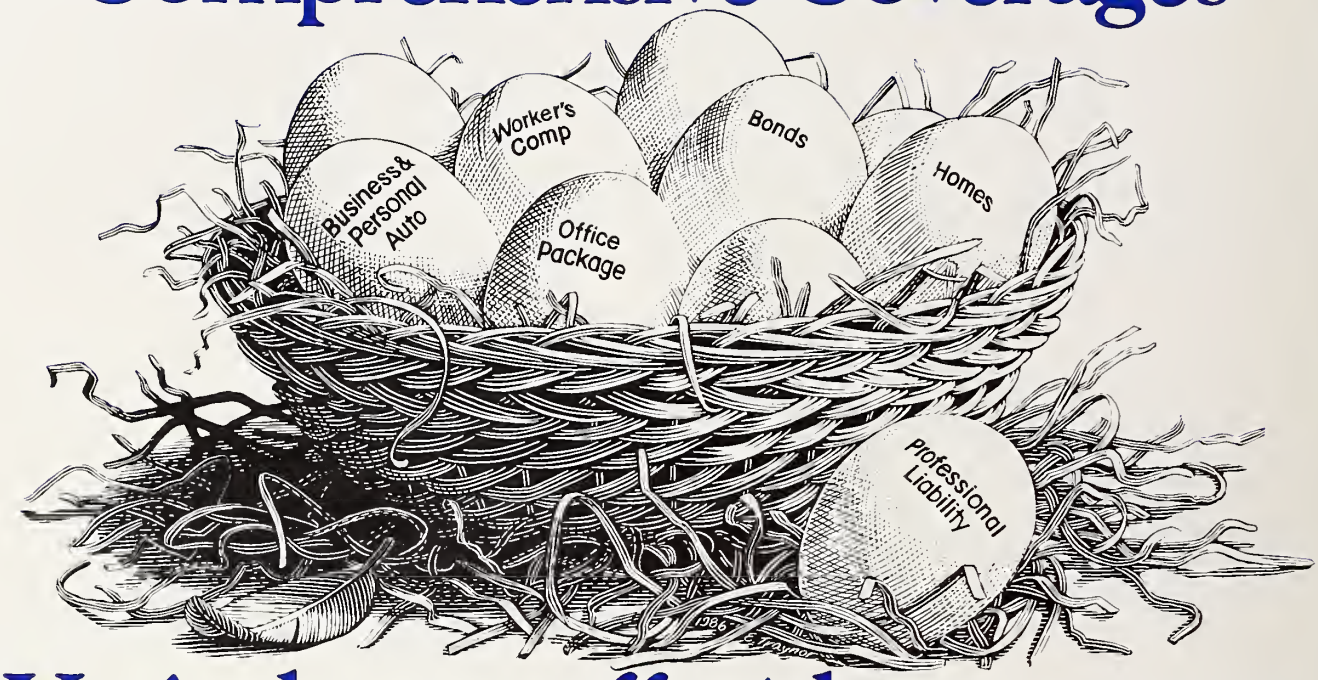


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# CONTENTS

VOLUME 76, NUMBER 9

## FEATURES

WESLEY WOODS GERIATRIC HOSPITAL
The first specialized hospital of its kind in the nation 622

EVALUATING THE DISABLED ELDERLY FOR PLACEMENT IN A SKILLED NURSING HOME 627
By Arthur O. Gelbart, M.D., R. Leon Longe, Pharm. D., and Richard E. Melcher, M.D.

GERIATRIC PSYCHIATRY — OPTIONS AND OPPORTUNITIES 629
By Mary Ann Camann, R.N., M.N.

PHYSICIAN AND COUNSELOR: TEAMWORK IN GERIATRIC CARE 632
By James K. Van Buren, M.D., and Joe Whitwell, S.T.D.

ARTHROSCOPIC SYNOVECTOMY IN THE RHEUMATOID METACARPOPHALANGEAL JOINT 638
By L. L. Wilkes, M.D.

MAG SCIENTIFIC ASSEMBLY NOVEMBER 1987 653

## EDITORIAL

THE IMPLICATIONS OF AIDS 620
By Harrison L. Rogers, Jr.

## X-RAY CHALLENGE

MULTIPLE PULMONARY NODULES WITH PLEURITIC CHEST PAIN 641
By Bruce Henschen, M.D., and Bashir A. Chaudhary, M.D.

## CANCER

ASPIRATION CYTOLOGY IN THE EVALUATION OF BREAST MASSES 643
By Charles M. Ferguson, M.D.

## HEART

ABSTRACTS FROM SYMPOSIUM ON CARDIOVASCULAR RESEARCH: PART III 648

## DEPARTMENTS

ABOUT THE COVER ARTIST: DALE RAYBURN 601
NEWS CAPSULES 602
LETTERS TO THE EDITOR 604
PRESIDENT'S PAGE 606
CALENDAR 607
ASSOCIATION NEWS 608
PHYSICIAN'S RECOGNITION AWARD RECIPIENTS 615
EDITOR'S CORNER 616
QUIET THOUGHTS 618
INDEX TO ADVERTISING/MANUSCRIPT INFORMATION 660

## COVER

The cover art, "Leisure Time," an etching by Marietta artist Dale Rayburn, introduces this issue of the *Journal* primarily devoted to the elderly. Read more about this talented artist on p. 601.

Cover photo and design: Chuck Rogers, Atlanta.

# Introducing A Hospital So New, It Can Take Care Of Age-Old Problems.

A new concept in health care for the elderly is now serving this region —the Wesley Woods Geriatric Teaching and Research Hospital.

As a Geriatric affiliate of the Robert W. Woodruff Health Sciences Center of Emory University, it is the first specialized hospital of its kind in the nation. Its purpose is to find answers to age-related problems that will face families for generations.

The Wesley Woods Geriatric Hospital is staffed and designed to address the complex physical, social, emotional and spiritual needs of the elderly. Outpatient services include a comprehensive health evaluation with the availability of medical specialists. Inpatient treatment units include an Alzheimer's Disease/Dementia Unit, a Psychiatry Unit, a Medical Unit and an Assessment Unit.

The Wesley Woods Hospital doesn't look like a hospital. Overlooking Peachtree Creek in a wooded setting, everything about the hospital, from the gray and white New England style exterior, to the warm peach-colored interior, is designed around one theme—the comfort and care of our patients and families.

The hospital is part of the Wesley Woods Center. The Center offers a variety of services to older people and their families including residential retirement living, intermediate care and skilled nursing care, respite care, Alzheimer's Disease care, family consultation and family counseling.

Admissions to the hospital can be made directly or through referral. Wesley Woods Hospital has an open medical staff so all physicians are invited to make an application.

Wesley Woods Hospital services are provided without regard to race, creed, color, national origin, handicap condition or age. Certified to participate in Medicare or Medicaid. Call (404) 728-6380 for further information.

**Wesley Woods Geriatric Teaching and Research Hospital**

**The Hospital For Generations To Come.**

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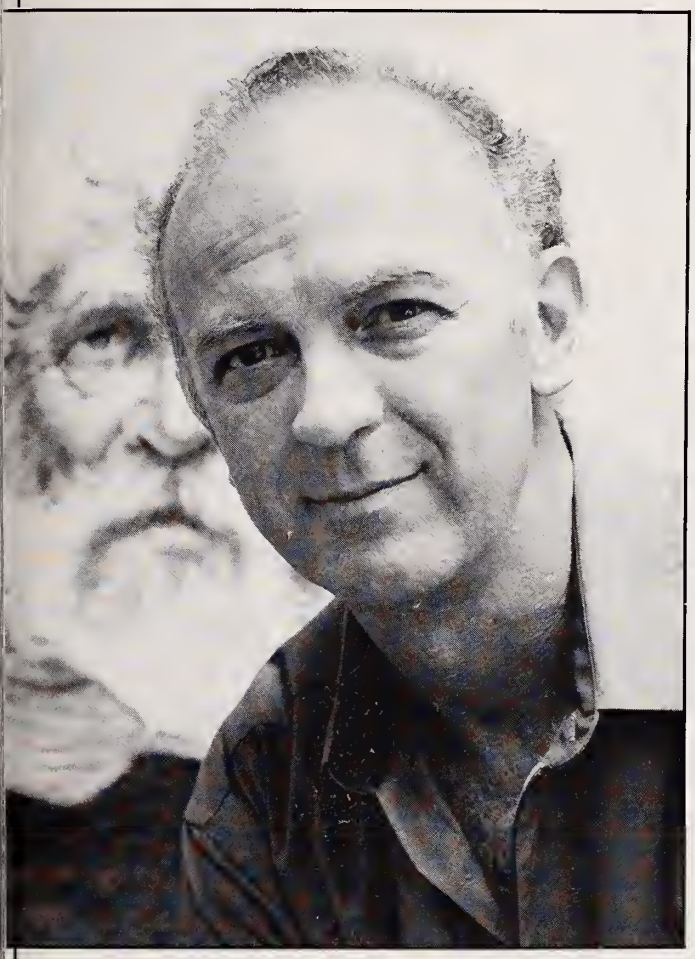
Geriatric affiliate of The Robert W. Woodruff Health Sciences Center of Emory University.

# About The Cover Artist:

# Dale Rayburn



INDIVIDUALS SHAPED AND MOLDED by life's joys as well as trials — individuals characterized by their permanence, by their ability to endure — it is these individuals who inhabit the artistic world of Dale Rayburn's paintings and etchings. It is fitting, then, that Mr. Rayburn's painting, "Leisure Time," should be featured on the cover of this month's *Journal* which looks at some of the special needs and concerns of our elderly patients — people who have endured and are endeavoring to regain or maintain their health and independence.

Born in Carriere, Mississippi, in 1942, Dale Rayburn considers himself fortunate that he is able to make his living doing what he loves most, yet he does not believe that he should compromise his own artistic integrity by simply catering to the artistic whims of the moment. He is glad that people collect his work and that they delight in it, but it is the work itself — being true to whatever idea which he wishes to portray — that is most important to him. As he noted, "if my work is good and honest, it will have merit." Mr. Rayburn's paintings are featured exclusively at the Lagerquist Gallery on Paces Ferry Place in Atlanta.

JURIED EXHIBITIONS
Boston Printmakers Annual Exhibition (Purchase Award)
Northwest Printmakers International Exhibition
Westchester Art Society Juried Graphics Exhibition
Miami Graphics Biennial
Georgia State University National Print Exhibition
Texas Fine Arts Association Painting Exhibition

PERMANENT COLLECTIONS
DeCordova Museum, Lincoln, Massachusetts
High Museum of Art, Atlanta, Georgia
White House, Washington, D.C.
Lamar Dodd Art Center
Albany Museum of Art
Mississippi Museum of Art
Southeastern Center for Contemporary Art
University of Mississippi
University of Georgia
Gibbs Museum, Charleston, South Carolina
Mint Museum, Charlotte, North Carolina

MUSEUMS AND GALLERIES EXHIBITED
Metropolitan Museum, Miami, Florida
Mississippi Museum of Art
DeCardova Museum, Lincoln, Massachusetts
High Museum of Art, Atlanta, Georgia
Seattle Art Museum, Seattle, Washington
Portland Art Museum, Portland, Washington
National Academy Gallery, New York
Mint Museum, Charlotte, North Carolina
Manufacturers Hanover Trust Bank Gallery, New York
Brooks Memorial Art Gallery, Memphis, Tennessee
Vincent Price Collection, Chicago, Illinois
Southeastern Center for Contemporary Art
Columbus Museum of Art, Columbus, Georgia

# AABB Establishes a National Autologous Blood Resource Center

THE AMERICAN ASSOCIATION OF BLOOD BANKS (AABB) has established a National Autologous Blood Resource Center (NABRC) to promote the use of autologous blood and to provide a consultation service to assist the medical community is establishing and utilizing autologous blood services. The growing interest by health care professionals and the public, and the rapidly increasing number of autologous blood programs, prompted the AABB to develop a professional source of information for both professionals and potential patients.

Autologous blood transfusion includes the donation and storage of blood for future need and the salvage and return of blood lost during and after surgery. As part of a total program of blood conservation, including intraoperative and perioperative hemodilution, the avoidance of inappropriate blood and component therapy, and the reduction of both surgical and diagnostic blood loss, autologous blood donation and transfusion provides for conservation and appropriate utilization of the limited blood resource. It also reduces complications related to banked blood transfusion, and can be a life-saving source of blood in emergency situations.

While blood transfusions are now as safe as possible, they will never be risk free. Transfusion risks should always be weighed against the potential benefits for each patient. Autologous blood transfusion is an effective way to reduce risks and preserve the community supply for those recipients who require homologous transfusions.

Physicians, blood bank specialists, and allied health professionals, as well as the public have become increasingly aware of autologous donation programs. A 1986 AABB public opinion survey found that nearly three-in-four (73 percent) of the 1000 respondents in the United States had heard of the autologous donation process, and that 80 percent of those surveyed would prefer to use this option if faced with surgery. Endorsement of autologous transfusion by the American Medical Association in late 1986 received much attention from the lay press and educated physicians and the public about the availability of this important transfusion option. The AMA's Council on Scientific Affairs called it "the safest type of blood for transfusion. It also decreases the demand for banked blood and eliminates the risk of infection and alloimmunization from a transfusion."

The American Association of Blood Banks is a non-profit medical organization representing community blood centers, hospital blood banks and hospital transfusion services. AABB members collect nearly half the nation's blood supply and transfuse approximately 90 percent of all the blood collected in the United States. The AABB has more than 2400 institutional members, including the Atlanta Red Cross and many hospitals throughout the state. There are also more than 8000 individual members including physicians, scientists, administrators, nurses, medical technologists, and others involved in blood banking and transfusion medicine.

The NABRC is staffed by an autologous blood specialist at the AABB National Office. The AABB Autologous Transfusion Committee members and AABB volunteers are available for consultations to assist physicians, hospitals and blood centers in the use of autologous services. The Center offers brochure and posters for both patients and professionals and also provides an annotated bibliography and detailed materials to institutions establishing or upgrading autologous blood services. Individuals are encouraged to write to the NABRC at the AABB National Office, 1117 North 19th Street, Suite 600, Arlington, VA 22209; or call the Red Cross Blood Center in Atlanta, 404-881-9800 or in Savannah 912-236-4241, for information regarding autologous donation services in the state of Georgia.

# American Cancer Society's Policy on Smoking

**The National Policy, dated August 1, 1987, states:**

I. The American Cancer Society has played a pioneering role in showing the clear relationship between smoking and disease. Accordingly, in view of the Society's highly visible position in this matter, ACS employees have an obligation to serve as exemplars. Therefore, smoking on the National Office premises or while representing ACS *will not be permitted.*
NOTE: Failure to abide by this revised No Smoking Policy will be addressed by management in the same manner as any other violation *of ACS Personnel Policy*. Effective date: August 1, 1986.

II. Potential candidates for hire who are smokers will not be hired. Effective date: August 1, 1987.

III. While recognizing that some current employees who smoke may desire special assistance in quitting, your ACS managemen

will take positive steps to help meet this challenge. In addition to making available self-help material, special FRESHSTART Quit Smoking Clinics will be offered at the National Office on ACS time to help those of you who may wish to take advantage of this no-cost-to-you program. Or, interested persons may want to participate in ongoing cessation clinics conducted by our New York City Division. Area Offices should utilize the programs as arranged by the Divisions, i.e. Eastern (Connecticut), Midwest (Illinois), Southern (Georgia), Western (Colorado). Whatever the case, the Society will make every effort to help you through the process; after all, we are the leading agency in promoting a smoke-free environment!

**Policy of the Georgia Division**

The policy on smoking in the orgia Division as adopted by the ecutive Committee on March 11, 87, was patterned after National's licy and is as follows:

. The American Cancer Society has played a pioneering role in showing the clear relationship between smoking and disease. Accordingly, in view of the Society's highly visible position in this matter, ACS employees have an obligation to serve as exemplars. Therefore, smoking on the premises (all ACS Offices and ACS leased vehicles) or while representing ACS, will not be permitted.
. Potential candidates for hire who are smokers will not be hired. Effective date: Immediately.
. While recognizing that some current employees who smoke may desire special assistance in quitting, your ACS management will take positive steps to help meet this challenge. In addition to making available self-help materials, special Fresh-Start Quit Smoking Clinics will be offered on ACS time to help those of you who may wish to take advantage of this no-cost-to-you program.

# Involuntary Smoking: Implications for Georgia

THE 1986 SURGEON GENERAL'S REPORT explored the health consequences incurred by involuntary smokers and they appeared to be significant.[1] The chemical composition of sidestream smoke (smoke emitted into the environment by a smoker between puffs) is similar to the mainstream smoke inhaled by the smoker. Data on environmental tobacco smoke (ETS) and nicotine absorption in nonsmokers suggest that nonsmokers can be exposed to levels of ETS that would be expected to generate a lung cancer risk. Epidemiological studies have documented an increased risk for lung cancer in ETS-exposed nonsmokers. Of 13 such studies, 11 demonstrated a positive relationship. The 1986 Surgeon General's Report reached three major conclusions:

- Involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers.
- Compared with children of nonsmoking parents, children whose parents smoke have an increased frequency of respiratory symptoms and infections. They also have slightly smaller rates of increase in lung function as the lung matures.
- Simple separation of smokers and nonsmokers within the same air space may reduce, but does not eliminate, ETS exposure.

The Surgeon General states, "Cigarette smoking is an addictive behavior, and the individual smoker must decide whether or not to continue that behavior; however, it is evident from the data . . . that the choice to smoke cannot interfere with the nonsmokers' right to breathe air free of tobacco smoke."[1]

*EDITORIAL NOTE:* Approximately 20% of the estimated 12,200 lung cancer deaths occurring annually in nonsmokers are attributable to environmental tobacco smoke.[2, 3] An increasing number of public and private sector institutions have adopted policies to protect individuals from ETS exposure by restricting the circumstances in which smoking is permitted. Laws restricting smoking in public places have been implemented with few problems and at little cost to state and local governments. Public opinion polls document strong and growing support for restricting or banning smoking in a wide range of public places.

On Wednesday, May 6, 1987, HHS Secretary Dr. Otis Bowen directed HHS officials to ban smoking in all offices, corridors, restrooms, and public spaces in HHS facilities nationwide.

*References*

1. Office on Smoking and Health. The health consequences of involuntary smoking: a report of the Surgeon General. Rockville, Maryland: Public Health Service, 1986.
2. National Research Council, National Academy of Sciences. Environmental tobacco smoke: measuring exposures and assessing health effects. Washington, D.C.: National Academy Press, 1986.
3. Repace JL, Lowrey AH. A quantitative estimate of nonsmokers' lung cancer risk from passive smoking. Environ Int 1985;11:3-22.

(Adapted from *MMWR*, 1986;35:769-770.)
(Reprinted from the *Georgia Epidemiology Report* 1987;3(5):3.)

## AIDS Policy

Dear Editor:

I compliment Dr. J. N. Gordon on his letter published in *JMAG* in May. His sensible viewpoint and obvious concern for the entire population will be heeded and adopted by more and more physicians, political figures and social leaders as the AIDS epidemic worsens. Denial of the extent of the problem leads to peculiar and ineffective responses. Entrenched special interests, such as the organized homosexual lobby, can block action only so long. It is sad nevertheless to see public officials responsible for the health of the entire population of the United States making special exceptions for those who want to continue dangerous sexual behavior without restraint. Public emergencies always require temporary abridgements of individual privileges and prerogatives. Thus, no one can claim privacy for the purpose of engaging in destructive and illegal behavior, whether such behavior is said to be voluntary or not. AIDS cases do not hesitate to call on the public for treatment when reckless endangerment of their health has led to overt disease.

I know full well from my own practice that so-called "education" avails almost nothing with people who are obsessed with certain kinds of behavior, addicted if you will. Often the immediate threat of death itself is needed to change such behavior. With AIDS, we cannot wait for such dire consequences to work their effect. This Association should use all its influence to persuade political and public health officials to adopt immediately the same kind of approach to AIDS contacts as is used with syphilis and certain other communicable diseases.

Sincerely,
*Stephen W. Edmondson, M.D.*
*Psychiatrist, Atlanta*

## Corrections and Comments on Special Hospital Issue

Dear Editor:

There is a statement in the article by Richard Greene (MAG General Counsel) appearing in the August, 1987, issue, pages 578-580, that needs correction. On page 579, it is stated that, "a Physician Reviewer is expected to review 10-20 complete hospitalization medical records per hour for which he is paid $50 to $60." At no point in time over the past 6-9 months to my knowledge has a physician, including myself, been told that such was expected. I have repeatedly emphasized to all physician advisors since 7/15/87, that a review must be thoughtful, reflecting a common sense, fair, and realistic appraisal of the medical record, that may take varying amounts of time. A production of 3-4 records per hour is possible for an experienced reviewer under the best of documentation circumstances, depending on the issues involved. However, there is no hard and fast production standard set forth by the Georgia Medical Care Foundation (GMCF). This same information has been provided to hospital staff meetings and specialty group meetings since I assumed the duties of Medical Director 7/15/87. The recruiting of qualified physicians for review of Medicare charts is my number one priority. We need the help and support of the MAG and of the entire practicing physician community to meet our goals for quality review. The article as a whole made a number of excellent points that should be of great help practicing physicians in dealing wi the review process of the GMCF.

Sincerely,
*Ralph A. Murphy, M.D., F.A.C.P*
*Medical Director,*
*Georgia Medical Care Foundation*

Dear Editor:

I have just read the MAG *Journ* for August 1987 and have several comments relative specifically to th article, "The Year 2000: A Look Into the Future of Hospitals and Medical Staffs," by Mr. W. Danie Barker (pp. 556-560). I certainly suspect the essence of his article is correct and because of this feel tha the medical profession will have failed in its intended purpose of "taking care of patients." Specifically, in the paragraph (section entitled), "Hospital/Medic Staff Relationships" (p. 560), he explores why the medical staff will be necessary and doesn't mention that patient care is important! Mayl we should drop the M.D. degree a take a degree in *Management* or *Business!*

Sincerely,
*G. David Maxwell, M.D., F.A.C.S*
*Athens*

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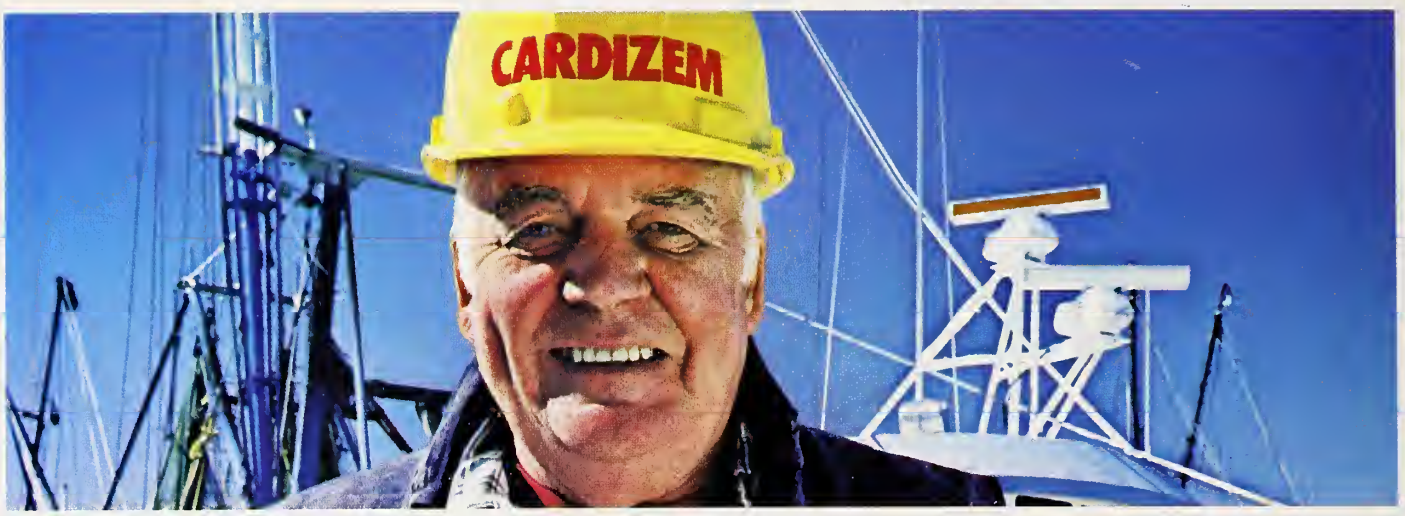


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# FEW SIDE EFFECTS IN ANTIANGINAL THERAPY

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CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

**WARNINGS**

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

**PRECAUTIONS**

**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

**Drug Interaction.** Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

**Pediatric Use.** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS**

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

| | |
|---|---|
| Cardiovascular: | Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope. |
| Nervous System: | Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor. |
| Gastrointestinal: | Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase. |
| Dermatologic: | Petechiae, pruritus, photosensitivity, urticaria. |
| Other: | Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties. |

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 9/86

See complete Professional Use Information before prescribing.

**References: 1.** Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983; 106(6):1341-1347. **2.** Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984;24(Dec):150-159. **3.** Johnston DL, Lesowoy R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687. **4.** Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. **5.** Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.

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# *Learning in Washington*

*Jack F. Menendez, M.D.*

RECENTLY, MAG sent a delegation to Washington to lobby against RAP DRGs. These lobbying trips are always interesting, so I thought I would share with you what happened during this trip.

Dr. John Watson, Dr. James Kaufmann, Mike Fowler, and I flew to Washington Monday afternoon, checked into our hotel, and then went immediately to an AMA briefing. The briefing was very detailed and brought us up to date on the RAP DRG language in the budget reconciliation bill. We were also told what amendments were in place to remove this language from the bill in the Ways and Means Committee. We were given papers on every aspect of the committee — the members, how they were likely to vote and how to approach our Congressmen. With what I already understood about the RAP DRGs and aided by the briefing, I felt reasonably confident I could discuss the issues.

The next morning, we went to the congressional office building to meet with our Congressmen. We tried to be on time for each appointment but the office buildings are HUGE and require lots of walking to get from place to place.

At each office, we announced ourselves to the secretary, were met by the Congressman's Legislative Assistant for Health (Health LA in the vernacular). The LA went over the issues with us before we met with the Congressmen. Jim Kaufmann was busily kissing all the secretaries, LAs, etc. It suddenly dawned on me that he had probably kissed more ladies that day than I had kissed in my entire life!

We were treated very cordially by our Congressional Delegation, I felt we had a free and fair exchange of ideas, and we all learned from the process.

After we finished our hectic schedule, we checked out of our hotel, and flew back to Atlanta. Our lobbying efforts are an expression of Democracy in Action. It is a very enjoyable experience, one gets the chance to see a part of the legislative process and actually be a part of it! The entire trip took 24 hours — it is an experience I will remember. I recommend it to anyone interested in the legislative process.

Jack F. Menéndez

# CALENDAR

## SEPTEMBER

7-19 — *Hilton Head Island, SC:* **9th nnual Frontiers in Nutrition.** Catgory 1 and AAFP prescribed credit. ontact Div. of Cont. Ed., MCG, Austa 30912. PH:404/828-3967.

7-19 — *Sea Island:* **Georgia Surical Society Annual Meeting.** Catgory 1 credit. Contact William C. lcGarity, M.D., Secy.-Treas., GSS, ept. of Surgery, 1365 Clifton Rd., tlanta 30322. PH:404/321-0111.

0-23 — *Hilton Head Island, SC:* **eorgia Obstetrical and Gynecogical Society Annual Meeting.** ontact Chester C. Lane, Executive irector, 69 Butler St., Atlanta 30303. H:404/659-0289.

3-Oct. 2 — *Atlanta:* **Magnetic Resnance Imaging.** Category 1 credit. ontact Office of CME, Emory Univ. ch. of Med., 1440 Clifton Rd., Atnta 30322. PH:404/727-5695.

)-Oct. 1 — *Macon:* **MAG Mutual ood Practice Seminars.** Category credit. Contact Wanda Duren, MAG utual Insurance Company, 1100 pring St., Ste. 750, Atlanta 30309. H:404/876-8858 or 800/282-4882 oll-free in GA).

)-Oct. 2 — *Savannah:* **11th Annual eonatology — The Sick Newborn.** ategory 1 and AAFP prescribed edit. Contact Div. of Cont. Ed., CG, Augusta 30912. PH:404/828-967.

## OCTOBER

4 — *Sea Island:* **Georgia Orthoaedic Society Annual Meeting.** ategory 1 credit. Contact David F. ople, Jr., M.D., Secy., GOS, 1938 eachtree Rd., Ste. 710, Atlanta )309. PH:404/352-2234.

10 — *Augusta:* **Obstetrics and ynecology.** Category 1 and AAFP escribed credit. Contact Div. of ont. Ed., MCG, Augusta 30912. H:404/828-3967.

— *Columbus:* **7th Annual Day of ndocrinology.** Category 1 credit. ontact Mrs. Judy Anderson, Internal edicine Foundation, P.O. Box 311, olumbus 31902-0311. PH:404/571-54.

8-9 — *Atlanta:* **Georgia Chapter, American Academy of Pediatrics Fall Meeting.** Category 1 credit. Contact William C. Mankin, Exec. Secy., Ga. Chapter, AAP, 4059 Land O'Lakes Dr., Atlanta 30342. PH:404/237-3922.

9 — *Atlanta:* **Clinical Advances in the Treatment of Disorders of Women: Psychiatric and Gynecological Perspectives.** Category 1 credit. Contact Emory Univ. Sch. of Med., Dept. of Psych., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

9-11 — *Atlanta:* **New Trends in Office Gastroenterology.** Category 1 and AAFP prescribed credit. Contact Div. of CME, MCG, Augusta 30912-6450. PH:404/828-3967.

10-14 — *Atlanta:* **American Society of Anesthesiologists Annual Meeting.** Category 1 credit. Contact AASA, 515 Busse Highway, Park Ridge, IL 60068. PH:312/825-5586.

12-16 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

14 — *Atlanta:* **9th Annual Joseph S. Skobba Symposium.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

19-20 — *Atlanta:* **Quantitative Thallium Myocardial Tomography.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

22-24 — *Atlanta:* **Alternatives to Cutaneous Urinary Diversion.** Category 1 credit. Contact Amer. Urological Assn. Ofc. of Educ., 6750 W. Loop South, Ste. 900, Bellaire, TX 77401. PH:713/665-7500.

26-30 — *Atlanta:* **American College of Chest Physicians.** Category 1 credit. Contact ACCP, 911 Busse Highway, Park Ridge, IL 60068. PH:312/698-2200.

28-29 — *Savannah:* **MAG Mutual Good Practice Seminars.** Category 1 credit. Contact Wanda Duren, MAG Mutual Ins. Co., 1100 Spring St., Ste. 750, Atlanta 30309. PH:404/876-8858 or 800/282-4882 (toll-free in GA).

29-30 — *Atlanta:* **Health Care: A Basic Human Need.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

30-31 — *Aiken, SC:* **Polyps, Polyposis, and Colorectal Cancer Course.** Category 1 credit. Contact Patty M. Winters, Dir., Jernigan Cancer Center, Univ. Hosp., 1350 Walton Way, Augusta 30910. PH:404/826-8900 or WATS:800/551-7957.

31-Nov. 3 — *Atlanta:* **Amer. Coll. Ob/Gyn District IV CME Meeting.** Category 1 credit. Contact ACOG Registrar, 600 Maryland Ave., SW, Ste. 300 East, Washington, D.C. 20024. PH:800/533-8811 x 341 or 202/638-5577.

## NOVEMBER

1-4 — *Unicoi State Park:* **24th Annual Psychiatric Institute on Group Behavior and Group Leadership.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

2-6 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

8-13 — *Atlanta:* **American Society of Plastic & Reconstructive Surgeons Annual Meeting.** Category 1 credit. Contact ASPRS, 233 N. Michigan Ave., Ste. 1900, Chicago, IL 60601. PH:312/850-1818.

12-14 — *Atlanta:* **Georgia Academy of Family Physicians Annual Meeting.** Category 1 and AAFP prescribed credit. Contact GAFP, 3760 LaVista Road, Ste. 100, Tucker 30084. PH:404/321-7445.

20-22 — *Atlanta:* **MAG Annual Scientific Assembly.** Category 1 credit. Contact MAG, 938 Peachtree St., Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

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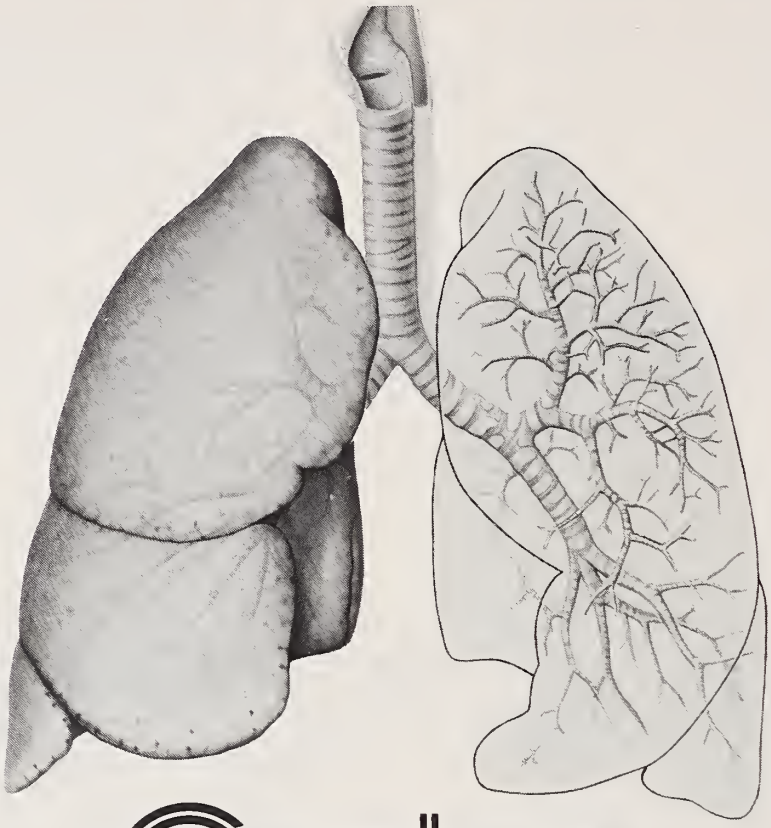

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- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
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**Adverse Reactions:** (percentage of patients)
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- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
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- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
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## MAG HOUSE ACTIONS

The MAG, at its 1987 House of Delegates, adopted Recommendation 1 of the Council on Legislation Report (Committee 16) which urged all MAG members to write Lieutenant Governor Zell Miller thanking him for his efforts and support in passing the Tort Reform measures that passed the 1987 Georgia General Assembly.

In order to carry out this recommendation, the MAG Board thought it appropriate for such a notice and request of its members be put in both the MAG Newsletter and MAG *Journal*.

The 1987 MAG House of Delegates adopted several amended recommendations of the Ad Hoc Committee on the Medical Care for the Disadvantaged which the Board of Directors recommended be published in the MAG Newsletter and the MAG *Journal*.

These House Actions are:

MAG reaffirmed its policy that no patient in Georgia be denied medical care for lack of funds.

MAG encourage the expansion of participation by physicians in public health clinic, food kitchens for the poor, services for street people, to needy refugees, farmers, and other groups who "fall between the cracks" of government funded medical assistance programs.

MAG encourage its members and other employers to provide health insurance coverage for all their employees, and urge insurance companies to facilitate this outcome.

## DEATHS

Rudolph Bell, M.D., of Thomasville, died recently from injuries received in a traffic accident last Spring.

A native of South Carolina, Dr. Bell lived in Thomasville for 57 years and was a pioneer in the field of urology and was founder of the urology department at Archbold Memorial Hospital.

He has served as president of the medical staff at Archbold and in a number of other capacities at the hospital until his retirement several years ago. He was a member of several medical organizations, and was a past president of the Thomas County Medical Society, the Georgia Urological Association, the Southeastern Section of the American Urological Association, and the Medical College of Georgia Foundation.

He is survived by his wife, one son and other relatives.

## QUOTES

*The immature mind hops from one thing to another; the mature mind seeks to follow through.*
HARRY A. OVERSTREET

*When your day is largely made up of energetic, concentrated effort, provide for periods of complete relaxation when you can take it easy and recharge your batteries.*
GRENVILLE KLEISER

*It must be great to be rich and let the other fellow keep up appearances.*
KIN HUBBARD

*Like the bee, we must make our industry our amusement.*
OLIVER GOLDSMITH

This space contributed as a public service.

# *Physician's Recognition Award Recipients*

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from January through March, 1987.*

*The Award was established by the AMA House of Delegates in 1968 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored for Category I credit by organizations accredited for these activities.*

*We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:*

Richard B. Abrohams, Marietta
Henry Alperin, Augusta
Rafael A. Alvarez, Milledgeville
Steven M. Amster, Jesup
John R. Andrews, Albany
Thomas S. Arnold, Augusta
Paul C. Atwater, Atlanta
Ezzat M. Aziz, Augusta
Roy A. Bakay, Atlanta
Phillip H. Beegle, Atlanta
Neil D. Boggess, Dalton
Donald J. Bradley, Columbus
Barry H. Braun, Hahira
Larry E. Brightwell, Columbus
Howard S. Brown, Atlanta
William O. Brown, Moultrie
Francis B. Buda, Atlanta
Charles W. Butler, Atlanta
Mary J. Cardin, Atlanta
David A. Causey, Blairsville
Yung S. Cheng, Savannah
Teresa E. Clark, Atlanta
David L. Cooper, Riverdale
Paul S. Crane, Decatur
Leon E. Curry, Metter
James O. Day, Griffin
Mina K. Dulcan, Atlanta
Ibrahim N. Elsahy, Riverdale
Ernest G. Fermanis, Atlanta
Stuart M. Finch, Augusta
Paul G. Firth, Hinesville
Frederick C. Flandry, Columbus
J. J. Gaines, Augusta
Karl V. Gallegos, Smyrna
John T. Godwin, Atlanta
Patrick A. M. Griffith, Atlanta
Michael A. Haberman, Atlanta
Lester M. Haddad, Savannah
L. Harvey Hamff, Atlanta
James E. Hinkle, Atlanta
Thomas L. Hodges, Clarkesville
William F. Hogan, Thomasville
Vendie H. Hooks, Augusta
Rafik B. Kashlan, Riverdale
Hyun H. Kim, Atlanta
Houston W. Kitchin, Clayton
David G. Laury, Savannah
Paul A. Lavietes, Atlanta
Walter E. Limehouse, Atlanta
D. Grier Marshburn, Atlanta
John D. McArthur, Lyons
James R. Mobley, Evans
E. Anthony Musarra, Marietta
Kim R. Nicola, Dalton
Hermann K. Orlet, Augusta
Dennis E. Ose, Savannah
Peter Phillips, Atlanta
Mario J. R. Ravry, Atlanta
Reuben S. Roberts, Hawkinsville
Sava M. Roberts, Augusta
Vance C. Roy, Albany
Indravadan C. Shah, Tifton
Paul I. Silverstein, Evans
Emory P. Smith, Statesboro
Hilton E. Smith, Columbus
Luther J. Smith, Columbus
Oliver A. Sorsdahl, Atlanta
Cyril O. Spann, Atlanta
Rex W. Tidwell, Macon
Fiameta R. Vargas, Alpharetta
Edward R. White, Roswell
Stewart E. Wiegand, Atlanta
Robert P. Wight, Tifton
John S. Wong, Dunwoody

# The Golden Years

*Charles R. Underwood, M.D.*

*Artist: Yvonne Randall, Marietta*

*"He lived his life like a river at the flood."*
*— (Max Eastman upon the life of his father)*

THERE ARE TWO PATHS upon which one may travel as they make their way through the ordinary and the unordinary life. And they diverge in a wood where one must realize, as Robert Frost would put it, the path chosen to follow "makes all the difference." There is the path marked "comfortable non concern" whereby the individual is at his or her leisure to be either unaware of, or unconcerned with, the consequences of growing older — perhaps with the certain assurance that whatever the end of their life may hold they are capable of accepting it. And then, there is the path available to those of us controlled by the fear and dread of the final trimester of one's life with all of the infirmities, the afflictions, the shame, and the guilt that it may harbor.

I left home to make Sunday morning rounds early a few weeks ago — cool and bright, a day fashioned for hope and confidence and filled with certainty that things were working well. I thought it best to stop by the nursing home on the way for there were a few elderly patients who for one reason or the other had been put off for the several weeks before. I thought little of the reasoning behind my unconscious ability to avoid making rounds at the

ırsing home. I walked by the
celess wheelchair, "Please, please,
ease, please" — a babble of
eaningless pleadings — or
eadings misunderstood. I breathed
eply of the olfactory sensations
nnipresent in that environment. I
oked at the withered, motionless
d paralyzed extremities. I read
ith heightening lack of
mprehension the useless recordings
sleepless nights and the
alfunctioning organ systems. I left
quickly as propriety allowed,
ıng open the exit door and breathed
eply. It was Sunday, bright and
eerful and confident — "On the
venth day thou shalt rest." What
deed had possessed me to take the
tour through this backwater of our
ily life?

I was about to go down the path
arked, "hazard — you are growing
der." It had been described by
ay Sarton, a contemporary
thoress usually read by my wife
d who writes poetry and novels
ually with a religious slant. She
d described a visit to a friend in a
rsing home: "Marynia, sitting in a
ıeelchair on the sun porch at the
ıton Park Home, looked me straight
the eyes for the half hour I was
ere, and recognized me at once
ıen I arrived. But she is not really
ere anymore, stroked my sleeve
mpulsively the whole time, as
ough I were a cat or dog. In the
ıeelchair beside her a very old lady
ept. It was excruciating to witness
s unassuageable grief, and I finally
d. How much stamina and grace of heart it takes for the nurses who see all this every day, knowing that none of these patients can get well, only worse day by day, for their illness is old age!" I shuddered. Could that be me someday, drooling and senseless, babbling in the wheelchair?

But then I thought, there lies the other path. It had been described by Hermann Hesse, the German who had written *Steppenwolf* and *Demian,* as well as many others who had viewed the aging process and those golden years with a bit more optimism. Hermann Hesse was in his fading years himself when in 1952 he looked back upon his life, "noticing, observing, contemplating become more and more a habit and exercise, and imperceptibly the mood and attitude of the beholder permeate our whole behavior. We, like the majority of men, have stormed through our years and decades of living, driven by wishes, dreams, desires, passions, impatient, tense, expectant, highly excited by fulfillment or by disappointment, and when today we cautiously leaf through the big picture book of our own lives, we are surprised at how beautiful and good it can be to have escaped that chase and pursuit and to have arrived at the *vita contemplativa*. Here in the garden of old age bloom many flowers to whose cultivation we once barely gave a thought. Here blooms the flower of patience, a noble blossom, we become more relaxed, more considerate, and the fewer our demands for participation and action become, the greater grows our ability to contemplate and listen to the life of nature and of our fellow men, to let that life stream past us without criticism and with ever-renewed astonishment at its variety, sometimes with solicitude and quiet pity, sometimes with laughter, with sheer joy, with humor."

I found my way to the hospital at last. It had a good smell to it — clean and antiseptic. It had a good look to it — people were hobbling but they were walking faster than yesterday. It had an optimism to it. People were getting well. People were dying too, of course, for that was indeed part of the big plan. Archie Bunker understood that — "Everybody's gotta die sometime. That's life."

The Sunday morning rounds seemed to grow a bit easier after I visited Melvin — his colon had been surgically assaulted for a malignancy a few days earlier and he responded to the query of how things were going by telling me — "Just trying to keep my spirits up, Doc. You know, if you don't keep your spirits up, you might be doing pretty well but you wouldn't know about it." Sunday rounds were over and somehow I seemed to have forgotten, or if not forgotten, to not worry about the faceless wheelchair. Melvin seemed to have come across those two paths in the wood himself and of importance, it seemed to me, had chosen the one marked, "Enter here those of you looking for the Golden Years." ■

# Quiet Thoughts

*Editor's Note: We plan to make "Quiet Thoughts" a regular or, depending upon our readers, an irregular feature of the* Journal. *You are invited to contribute to this section, as is your wife, your office staff, your minister, or whoever you may know who has something brief and interesting to say about the human condition.*

*The following piece was first published in the* Journal *in April, 1979, and as our featured subject of this month's issue has to do with the care of the elderly, we thought it deserved to be printed again. There is much that is serious and depressing about caring for our elderly patients — humor helps us keep some perspective, and the following piece offers us some humorous relief.*

## Anna's Story

**Susan J. Dillon**

A FRIEND OF MINE, a gentle lady named Anna McKeown, was sick recently and spent some time in a local hospital. I visited her not long ago, and she told me a story which, like many things associated with the human condition, is infuriating, funny, and poignant — all at the same time. This is Anna's story:

You remember I had been in the hospital for several days, with a tube in my veins, and someone coming in every little while to check on me and give me my medicine. I'm 92, you know, and my breath was becoming short at times and real long at times. I'm certain that the nurses expected the Lord to come for me at any moment. I certainly thought so, and without a doubt He someday will, since I have become convinced that I am mortal.

So there I was, staring at the ceiling, picking at the bed covers, and feeling that I did not count for much in the world anymore. And I felt that it was not very important whether I did or did not care, anyway, since what was happening to me was inevitable, even though it was inconvenient. And then it started. Strange waves began to come over me, one after the other, and I felt terrible.

It was early morning when all of this happened. It seems like this is the time that most people die, and apparently it was now time for me. The Big Time. The Final Time. I was indeed a flower being picked for God's garden. And I knew it. I was as ready as I can get. Which, to tell you the truth, was not very ready.

I pushed the call button as my last act, and waited for Florence Nightingale to come in on rubber-soled shoes. I longed to simply hold someone's hand as I crossed the chasm between this world and the next.

A nice voice came over the intercom and said, "Yes, anything I can do for you?"

"Yes," I answered. "I'm dying, at least I think I'm dying. Won't somebody please come and give me something?"

But Florence was delayed, and her stand-in yelled at me over the intercom, "Just a minute."

Ms. Dillon is managing editor of the *Journal.*

"Just a minute." When the raven of gloom and eternal sleep was propped on Poe's door sill, at least the bird had the grace to say "Nevermore." And so, I waited, still longing for the touch of a human hand, and the soft and private slumber that must be the peace of a freezing man, began to ease me into eternity — until I was interrupted.

The door opened, and I saw the female form of a cleaning lady that looked to weigh something less than a half-ton GMC truck, with legs like small beer kegs. She was wearing rough work gloves, and she carried a mop. Her voice was somewhat less scratchy than millstones in action.

And she was all business with that mop. She mopped and mopped. But since people need people in desperate times, and since I needed someone to hold my hand and to ease me into Heaven with dignity and the love of a fellow creature, she would have to do (absent Florence). So I said, softly, with one of my last remaining breaths, "Please come over here and hold my hand. I'm dying."

Her response was not what I expected. In fact, there was no response at all for quite a while. She just kept scrubbing with that mop. I repeated my feeble moan, "I'm dying. Won't you *please* come hold my hand for just a minute?"

"Oh, get on with your dying. I ain't got no time to hold your hand. I got to clean up this room and get it ready. You don't need no help dying." Saying this, she finished her work and left.

Another wave started coming on just then, but this time it was anger — pure anger. I began to get strength, like Popeye eating spinach, and I got out of that bed and went to the door. As I opened it, I caught site of her skirts as she disappeared around the corner. I yelled after her, "You're just going to have to come back tomorrow and clean up again, because I'm not going to die."

I went back to my bed, picked up the phone, and ordered a pot of tea and a good breakfast and ate and drank the whole thing. My heart is as strong as garlic, and I take Inderal just to keep my doctor from nagging. And I'm going to keep eating popcorn. With salt. Florence can wait.

# The Implications of AIDS

**Harrison L. Rogers, Jr., M.D.**

AIDS IS A PUBLIC HEALTH ISSUE with growing medical, social, legal, financial, and ethical implications. It is a communicable disease for which no effective treatment exists today — and it is fatal! Today's information indicates that it is spread mainly through homosexual activity and IV drug use. Heterosexuals and recipients of blood products or organs make up a small percentage of the total. We can be proud of the results of our research community which has provided so much information about a disease first diagnosed just 6 years ago.

The medical implications are clear andwe must not allow other aspects of this disease to obscure our primary responsibility: first, to treat those with the disease with competence and compassion; second, to provide the best information possible for those found to be serologically positive for HIV who do not have the disease. They must be informed of their prognosis and equally important, informed of the risk of spreading the disease by engaging in sexual activities with unsuspecting partners or by donating blood or organs. These individuals at risk include contacts made during the preceding several years and must be located and tested to prevent even wider dissemination of the virus.

As with any communicable disease, we also have a responsibility to protect health workers who will be involved in the care of AIDS patients, as well as to protect other patients in our institutions who might be exposed. Our patients also have the right to know that all health workers involved with their care are seronegative for HIV. For those of us found to be seropositive, we must adhere strictly to scientific, medically developed guidelines for disclosure. Our profession must accept the responsibility to provide factual education for the general public. This includes elected officials, regulatory bodies, courts and the entire educational system so all can make informed decisions on the multiple issues which will arise.

The social implications of the disease are impressive. First, education of the public, especially those at greatest risk, involves going into our schools with explicit information for our children at an early enough age to offer real help in avoiding unwitting exposure to AIDS. This is a change from our past policy, but it has been vigorously supported by Surgeon General Koop and now by the AMA as well.

Second, it is mandatory that the high risk groups be educated so as to make the drastic changes in their lifestyles that are necessary. We have seen encouraging change already, but the job is just beginning.

Third, the devasstating effects of revealing that one is seropositive *and* homosexual requires special help to the patient, families, neighbors, and coworkers as well.

The legal implications of the diseaes are numerous and involve two broad areas: (1) confidentiality of my patient's affairs and (2) a responsibility to the public at large to enable it to avoid contact with this fatal disease. We continue to believe that our patients' confidences must be sacrosanct. However, it is mandatory that we provide this information to our fellow health workers who also care for this patient who is seropositive. We must be assured that the unsuspecting contacts of this patient can be identified and tested. Furthermore, society must consider sanctions for the infected individual who knowingly exposes others to the disease. State legislatures have already considered proposals for quarantine, which are tantamount to imprisonment, and these bodies need our help in defining medically — scientifically — the threat posed by the seropositive individual and the actual limits of that threat to society. An informed legislature should provide the support necessary to care for these patients and to protect them from unfounded discrimination by society.

The financial implications of AIDS are serious and growing by leaps and bounds. The research effort has been remarkable, and if we

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re to see progress in the forseeable ıture, we must continue to support ıis effort with money. The cost of ıe only drug even slightly effective ı slowing the progress of AIDS AZT) is over $5000 per year per atient. The cost of hospitalization or those who develop AIDS varies om $20,000 to $40,000 per year. 'hey frequently require ospitalization, and as the disease rogresses, many well require ICU are on a regular basis. The cost of ıe educational efforts described arlier will be very large even if oordinated and directed on a ational basis. These patients, early ı the progress of their disease, equently can no longer work and ıpidly exhaust their own resources. 'hey become a financial burden for ıeir family and often end up as ards of the state. As they loose ıeir jobs, their health insurance is lso lost, never to be regained. An nexpected cost to many life ısurance carriers was noted when ıdividuals who discovered ıemselves to be seropositive urchased large life insurance olicies. These individuals had short fe expectancies, and the carriers had o way of identifying the risk.

The ethical implications of the AIDS epidemic center on my esponsibility to my patient. I must e certain that he or she receives all eeded medical and social services, alancing my need to protect his or er privacy with the need to protect the public. Some of our colleagues have refused to care for these patients — a situation which must be condemned. Historically, we have served all the public and can only survive as a profession if we continue to do so. Disclosure of my patient's seropositive test must be done judicially — and disclosure of *my* seropositivity must be as well. The decision as to how I can continue to practice must be made on scientific grounds alone.

The AMA House of Delegates in June considered a Board of Trustees Report on AIDS and adopted it with a few modifications. This report recommends:

1. Mandatory testing of donors of blood and blood fractions, organs, tissues, semen and ova; inmates in federal and state prisons; immigrants to the United States; military personnel.
2. Routine, voluntary testing with informed consent for the following types of individuals who are from areas with a high incidence of AIDS or who engage in high risk behavior: patients at sexually transmitted disease clinics and drug abuse clinics; pregnant women in their first trimester of pregnancy; people seeking family planning services; patients who require surgical or other invasive procedures. (If the voluntary policy is not sufficiently accepted by such patients, the hospital and medical staff should consider implementing a mandatory program.)
3. As a matter of medical judgment, voluntary testing should be encouraged for: individuals whose history of clinical status warrants this measure; anyone who is homosexual, bisexual or has a history of intravenous drug use; and anyone who is the sexual partner of anyone in these groups.

Hospitals in our state which have five to 10 AIDS patients daily, must be considered "areas with a high incidence of AIDS." Furthermore, patients admitted to our hospitals may not enter expecting an invasive procedure — but most end up having one before discharge. It is my feeling that in these institution *all* patients and *all* health workers (including physicians) should undergo routine testing.

The AIDS issue is growing rapidly in all dimensions with constant accentuation of all my listed "implications." It is imperative that our profession face the problem squarely and offer our very best advice to the public — our patients — and our colleagues. I am pleased that MAG has established a special AIDS Committee to track advances in the diagnosis and treatment of AIDS as well as to share this information with the public and our profession on a timely basis. ■

# Wesley Woods Geriatric Hospital

## The first specialized hospital of its kind in the nation

**Irene S. Harkness**

"YOU NEVER GAVE UP on me," said Mrs. J. when she visited the staff to bring them a plate of brownies.

Though she is well over 80 years old, the staff of the Geriatric Hospital was determined to reach her in the shell she had withdrawn into. Having been severely depressed for some time, she is now back home, living independently and feeling good about herself again.

There is a small hospital in Atlanta undertaking a large task of providing specialized acute care for the elderly. As Geriatric Affiliate of the Robert W. Woodruff Health Sciences Center of Emory University, the Wesley Woods Geriatric Hospital is the first specialized hospital of its kind in the nation. Its purpose is to find answers to age-related problems that will face families for generations.

Ms. Harkness is Director of Public Relations, Wesley Woods Center, 1817 Clifton Rd., Atlanta, GA 30029-5102. Send reprint requests to her.

The idea for this Geriatric Hospital was developed from Wesley Woods' desire to better serve the burgeoning number of older people and through the encouragement of the former Dean of the Emory School of Medicine and other Emory leaders who wanted to incorporate geriatrics into their program.

Recognizing that other community hospitals were available to handle surgical procedures, William L. Minnix, director of the Wesley

*"It's a hospital that doesn't look like a hospital." The Geriatric Hospital at Wesley Woods Center in Atlanta is designed around one theme: the comfort and care of elderly patients and their families.*

Woods Center, said that the Center set its sights on developing a hospital that would "diagnose and treat some of the illnesses and conditions of the elderly that have not been identified and treated adequately."

Opened in March of 1987, the Geriatric Hospital delivers treatment by a multidisciplinary team, including referring physicians, registered nurses, activity therapists, social workers, a chaplain, physical therapists, and psychologists who participate in developing the patient's treatment program. The medical team works closely with patient and family members to develop the proper treatment program specific to the patient's needs.

*The Geriatric Hospital delivers treatment by a multi-disciplinary team who participate in developing the patient's treatment program. The medical team works closely with patient and family members to develop the proper treatment program specific to the patient's needs.*

"We have seen some dramatic examples of where the spiritual, psychologic, social, and medical aspects of the older patients contribute to their health. You have to look at all of these factors when helping an older person get well," said Joan Carlson, associate director of the Center. It is also important to include the family in the healing process in Geriatrics. At the Center, families are involved in holistic planning from the very beginning.

***Assessment services and treatment services are available to help older persons and their families deal with the mental health changes related to aging.***

The Hospital offers a full range of services. Inpatient services include an Alzheimer's Disease/Dementia Unit, a Medical Unit, an Assessment Unit, and a Psychiatry Unit. It is equipped and staffed to provide comprehensive acute care, with the exception of major surgery. Minor surgery and other procedures such as CT scans, X-rays and laboratory services are provided.

The Wesley Woods Clinic, located in the hospital, offers a variety of outpatient services, including general internal medicine, psychiatric care, specialty clinics in Alzheimer's Disease, Parkinson's Disease and arthritis, and outpatient ancillary services.

The Hospital has an open medical staff composed of 120 Emory and community physicians. Physicians are invited to make application. Admission to the Hospital can be arranged through the family physician, who can either admit directly or make referral arrangements.

Dr. Herbert R. Karp, professor of Neurology at Emory, has been the Wesley Woods Center's Medical Director since 1983.

Dr. David R. Bulmer, associate professor of

*It is also important to include the family in the healing process in Geriatrics. At the Center, families are involved in holistic planning from the very beginning.*

Psychiatry at Emory, is the Wesley Woods Center's Chief of Psychiatry. Bulmer is providing inpatient and outpatient psychiatric evaluation and treatment.

Dr. James K. Van Buren is Chief of Medicine at Wesley Woods. An internist and specialist in pulmonary medicine, he practices at Wesley Woods Hospital and at Crawford W. Long Hospital. He has been associated with Wesley Woods since its inception and serves on the Hospital's Board of Trustees.

Dr. Dorothy Karandanis is the Director of the Wesley Woods Clinic. Karandanis comes to the hospital with extensive experience in internal medicine and staffs the Clinic 5 days a week.

Dr. Ray Watts and Dr. Hugh Spruell are directing the Specialty clinics of Parkinson's Disease and Arthritis, respectively. Associated with the Department of Neurology at Emory, Watts is conducting research in Parkinson's Disease in addition to the treatment clinic he conducts. Spruell is an Emory graduate who practices in Decatur and specializes in rheumatology.

The Hospital also allows students and Emory instructors research and educational opportunities with the aging population.

***Opened in March of 1987, the Geriatric Hospital offers a full range of services. Inpatient services include an Alzheimer's Disease/ Dementia Unit, a Medical Unit, an Assessment Unit, and a Psychiatry Unit.***

Clinical research focuses on Alzheimer's Disease/Dementia, sleep disorders, Parkinson's disease, depression, and other problems of the central nervous system.

"The goal of including rotations at the hospital is to encourage more medical

students to enter the geriatric specialty and to educate them on the care of the elderly," Carlson said.

"There are many factors in aging that contribute to health," said Carlson. "Psychologic is one of the most important. Most acute care hospitals denote stress to people. We wanted our hospital to look and feel like a comfortable place to be. That in itself would lend itself to the healing process."

Research verifies that individuals have physiologic reactions to color, despite their preferences. As a result, the architectural design of the interior and exterior of the hospital aligns with Wesley's holistic approach to health care. In addition, a unique floor was developed to meet the specific needs of an aging population. It's a hospital that doesn't look like a hospital. Overlooking Peachtree Creek in a wooded setting, everything about the hospital, from the gray and white New England style exterior to the warm, peach-colored interior, is designed around one theme — the comfort and care of patients and their families.

"This facility represents a clear breakthrough in geriatric care in the United States," said Lorraine G. Hiatt, Ph.D., Environmental Psychological/Gerontology consultant, "based on my visits to over 500 facilities in the past 15 years. It is an intimate hospital . . . unusual in itself and as a site for older people."

The "butterfly plan" or cluster plan designed for this hospital allows for a residential atmosphere in an acute care hospital and provides a hierarchy of spaces for patients and opportunities for socialization. Socialization stimulates and patients are at their best when in a home-like environment. As a result, they maintain a greater sense of independence.

Patient rooms are located in four pods with 25 beds in each. There are no long halls. Rooms surround a dining and two living room settings which, in turn, surround the nursing station.

Many of the issues connected with aging involve pain, loss, changes in status and role, and increased isolation. These changes can demand coping and adaptation that can at times seem overwhelming. Assistance may be an important part of successfully working through these issues. Assessment services and treatment services are available to help older persons and their families deal with the mental health changes related to aging.

The Hospital and Clinic participate in Medicare and Medicaid and accept patients on a non-discriminatory basis.

This hospital completes the full-service residential and health care complex at the Wesley Woods Center. ■

# Evaluating the Disabled Elderly for Placement in a Skilled Nursing Home

**Arthur O. Gelbart, M.D., R. Leon Longe, Pharm.D., Richard E. Melcher, M.D.**

DISABILITY, DEPENDENCY, AND LONG-TERM CARE often describe the progressive decline in the condition of many of our elderly patients. The number of dependent elderly increases each year, placing a great burden on families and society. Although only 5 percent reside in nursing homes at any given time, one out of four elderly persons will need long-term care assistance during their later years. Nursing home utilization has doubled since the introduction of Medicare and Medicaid in 1966. There are one and a half million nursing home beds, and Medicare expenditures already exceed 15 billion dollars annually.[1] The primary care physician who cares for an ever-increasing population of elderly patients occupies a pivotal role in the evaluation and placement process.

When the physical and emotional burden of maintaining a disabled elderly patient in the home becomes overwhelming, nursing home placement becomes necessary. In addition, some patients must be placed in such long-term facilities because their needs demand more intense medical supervision. When placement occurs, there is certain vital information that should be supplied to the nursing home personnel to provide for the best medical services to the patient. This information enables nursing home personnel and assigned physicians to adequately meet the needs of the disabled person and to maintain the highest level of patient function.

**The referral information that we suggest for admission should help to determine the level of care and rehabilitative potential of the patient.**

In providing care for a large number of patients in a skilled care facility that serves as a teaching nursing home, we have found many referrals to be deficient in information regarding need for placement as well as

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patient limitations.[2] It is difficult to determine whether alternate placement has been considered. There are a number of options that the primary physician can explore before placing an elderly patient in a skilled care facility. It is important to remember that long-care is not synonymous with nursing home placement. Alternative services include in-home aides, day care, supervised boarding homes, and intermediate care facilities. A skilled care placement is the best option for the person who requires 24-hour monitoring and nursing care.

The actual reason for most nursing home placement is that the patient, family, and other community services can no longer meet everyone's needs. Far too often, we have received patient referals with a transfer record listing important physical diagnoses such as cancer or heart disease as the reason for placement. This information does not convey whether it is necessary for the patient to reside in a skilled care facility. The degree of patient disability is unclear from this paucity of information.

To provide an accurate assessment of a patient requiring long-term skilled care, we have found the following format very useful. In contrast to the routine history and physical, this information on the disabled elderly provides a realistic functional appraisal which assists nursing home personnel in the day to day care of the patient.[2-4]

I. *Physical Diagnoses.* Provide a listing of medical diseases and surgical procedures (e.g., stroke, cancer, heart disease, Parkinson's disease).

II. *Functional Assessment.* Describe the tasks of daily living. Is the patient able to walk? Does he transfer from wheelchair to bed? Is he in need of assistance when bathing, dressing or eating? Does he need assistance with toileting? Is he incontinent of bowel or bladder? Does he communicate with any difficulty?

III. *Psychiatric Evaluation.* (The physician need not be a psychiatrist to make this evaluation).

   A. Describe the patient's mental status. Is he/she oriented to time, place, and person? Evaluate his/her remote and recent memory, intellectual function and judgement.[5]

   B. Is he/she depressed or euphoric? Does he/she have a history of psychosis, delusions, or hallucinations? Does the patient display hostility or aggressive behavior that could endanger staff or other patients? Does he/she require psychotropic medications? Most importantly, is the patient competent?

IV. *Social History.* Describe the patient's relationship with his or her family. Is the patient able to interact satisfactorily with other people? Does the patient accept his or her need for nursing facility placement?

V. *Medication History.* Does the patient have difficulty with medication compliance? Does his/her mental or physical condition interfere with compliance? Does he/she have a history of alcohol or substance abuse?

VI. *Rehabilitation Potential and Prognosis.* What are the patient and family expectations? What are the physician's goals? What would the patient's living arrangements be after discharge from the facility? Does the patient feel that this is the end of the road?

## Summary

The referral information that we suggest for admission should help to determine the level of care and rehabilitative potential of the patient. A skilled care facility should have definite and realistic goals for every patient, and the patient should benefit from the placement. The information is reviewed by the medical director, nursing director, social worker, and therapists from a variety of available consulting disciplines. With this information, the need for skilled care can be more accurately determined, and a level of care provided that attends to the total patient.

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# To show you how many hypertensives stayed on

# INDERAL® LA
(PROPRANOLOL HCl)

# after a major nationwide trial...

...we had
to find
just the
right room.

# 60,073 patients (90%) who started on INDERAL® LA stayed on INDERAL LA.[1*]

## Surprising? Not really.

Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.
A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients[2] revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol—which shows how well-tolerated once-daily INDERAL LA can be.

## Sole therapy or concomitant therapy? Fifty-nine percent of the time, INDERAL LA stood on its own.

The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were treated merely with the addition of a diuretic to INDERAL LA.

## For the noncompliant patients in your practice, INDERAL LA may well be the answer.

Almost 20,000 of the patients in the nationwide compliance trial were identified as having been noncompliant with their previous antihypertensive therapy. Their physicians reported that 88% showed improved compliance when placed on once-daily INDERAL LA.

# Control, comfort, and compliance

ONCE-DAILY
**INDERAL® LA**
(PROPRANOLOL HCl)
LONG ACTING CAPSULES

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

## The one you know best keeps looking better

NOW AVAILABLE...
NEW LOW DOSE
INDERAL LA 60 mg
LONG ACTING CAPSULES
(PROPRANOLOL HCl)

Please see next page for brief summary of prescribing information.

# The one you know best keeps looking better

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION. SEE PACKAGE CIRCULAR.)*

**INDERAL® LA** brand of propranolol hydrochloride **(Long Acting Capsules)**

**DESCRIPTION.** INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

**CLINICAL PHARMACOLOGY.** INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

**INDICATIONS AND USAGE. Hypertension:** INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

**Angina Pectoris Due to Coronary Atherosclerosis:** INDERAL LA is indicated for the long-term management of patients with angina pectoris.

**Migraine:** INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

**Hypertrophic Subaortic Stenosis:** INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

**CONTRAINDICATIONS.** INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

**WARNINGS.** CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

**Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)**—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing $T_4$ and reverse $T_3$, and decreasing $T_3$.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

**PRECAUTIONS.** GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

*Aluminum hydroxide gel* greatly reduces intestinal absorption of propranolol.

*Ethanol* slows the rate of absorption of propranolol.

*Phenytoin, phenobarbitone,* and *rifampin* accelerate propranolol clearance.

*Chlorpromazine,* when used concomitantly with propranolol, results in increased plasma levels of both drugs.

*Antipyrine* and *lidocaine* have reduced clearance when used concomitantly with propranolol.

*Thyroxine* may result in a lower than expected $T_3$ concentration when used concomitantly with propranolol.

*Cimetidine* decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

*Theophylline* clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS.** Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

*Cardiovascular:* Bradycardia, congestive heart failure; intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

*Central Nervous System:* Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy and vivid dreams appear dose related.

*Gastrointestinal:* Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

*Allergic:* Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

*Respiratory:* Bronchospasm.

*Hematologic:* Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

*Auto-Immune:* In extremely rare instances, systemic lupus erythematosus has been reported.

*Miscellaneous:* Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

**DOSAGE AND ADMINISTRATION.** INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

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# Geriatric Psychiatry — Options and Opportunities

**Mary Ann Camann, R.N., M.N.**

*"To me, fair friend, you can be old,*
*For as you were when first your eye I ey'd,*
*Such seems your beauty still."*

SHAKESPEARE, SONNET CIV

GROWING OLDER may lead to many changes that challenge the mind and body to cope or adapt. Acceptance of the changes brought by older age is a developmental challenge not to be taken lightly, but mental illness and depression do not have to be viewed as an inevitable part of aging. The commonly held belief that many or most elderly persons will eventually experience significant changes in mental status can lead to failure to recognize treatable depression. Such assumptions may be transformed into a fear and anxiety in the minds of many older persons that loss of control over their lives is inevitable. This often causes withdrawal and preoccupation with changes and may thus confirm the belief that decline is inevitable.[1]

The cause and effect relationship is seldom obvious in changes in mental status. In a recent study, the presence of mental disorder was the single most important factor precipitating nursing home admission, because it resulted in a high dependency factor.[2] Changes in mental status are often not reported until a crisis occurs that taxes the abilities of the aged person or his or her support network.

There is growing recognition that older persons represent the age group most vulnerable to episodic or chronic states of depression. Prevalance studies suggest that as many as 15-20% of persons over 65 and living in the community show significant depressive symptomatology.[3] Further, it has been noted that as many as 15% of the elderly patients dignosed as demented by their physicians were later evaluated as suffering from depressive illness.[4]

Many issues connected with aging involved pain, loss, and change in role and/or social relationships. Dealing with these issues can stress coping and adaptation responses. The presentation of depression in the aged person is often first noted by preoccupation with various somatic and psychosocial stresses. A given clinical picture including depression may emerge in an aged person as a result of several interrelated causes and situations, creating a tapestry of symptoms with depression only mentioned, if at all, as an "of course" phenomena.

The family members and friends of the aged person, who are most concerned and observant in monitoring changes in physical status, may minimize depressive symptoms because of the feared implications for changes in role, status, and relationship expectations.

Awareness of the presence of depression may be aided by the recognition of symptom groups. Five classes of symptoms have been reported by Lewinsohn, Biglan, and Zeiss (1976) as being important in the recognition of depression and depressive disorders.

1. *Dysphoria* — feelings domi-

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nated by sadness, apathy, and boredom, including loss of gratification and lack of feeling or interest. "I no longer enjoy things I used to."

2. *Behavioral Deficits* — inability to actively participate socially and decreased verbal and physical activity, including psychomotor retardation. "I feel like an outsider and a burden."
3. *Behavioral Excesses* — excessive complaints about life situations and feelings of guilt, self doubt and uncertainty. "I can't make up my mind." "No one cares about me."
4. *Somatic Symptoms* — headache, sleep problems, fatigue, poor appetite, gastrointestinal complaints, vertigo, and episodes of intermittent tachycardia.
5. *"Cognitive"* — manifestations that reflect feelings of failure, difficulty concentrating, and negative expectations. Often helplessness and powerlessness predominate.[5]

When depression is recognized, the availability of geriatric psychiatry services makes it more likely that consultation will be sought.

A 16th century physician, John Weyer, wrote that the goal of medicine is to make the obscure clinical picture obvious and understandable in the light of day.[6] Acknowledgement of the possibility of depression in the clinical picture gives the patient and family permission to explore its manifestation in the life of the older person. The availability of services especially devoted to the psychiatric needs of the older person can make treatment more acceptable to families and clinicians, as well as to patients.

The geriatric psychiatry program at Wesley Woods Geriatric Hospital is designed specifically to address the mental health issues and needs related to aging, including depression. Both outpatient and inpatient assessment and treatment services are offered in a home-like atmosphere that places emphasis on the individual.

The program is designed to offer a full range of professional services and treatment options and opportunities for problem resolution. Services are provided by an interdisciplinary team, under the direction of the admitting psychiatrist, and include several consulting specialists in various areas: Registered Nurses, and professionals from the fields of Activity Therapy, Social Work, Psychology, Physical and Occupational Therapy, and Chaplaincy.

The program gently explores the potential of each individual and directs effort toward optimal medical treatment as well as psychosocial support, sensory experiences, and cognitive experiences that support and direct a return to optimal wellness. A recent client said, "people keep telling me not to think about getting older, but I'm 84 and need to do some thinking." Geriatric psychiatry services offer options, opportunities, and atmosphere to think, feel, review, and heal within a framework of psychiatric care and peer group support.

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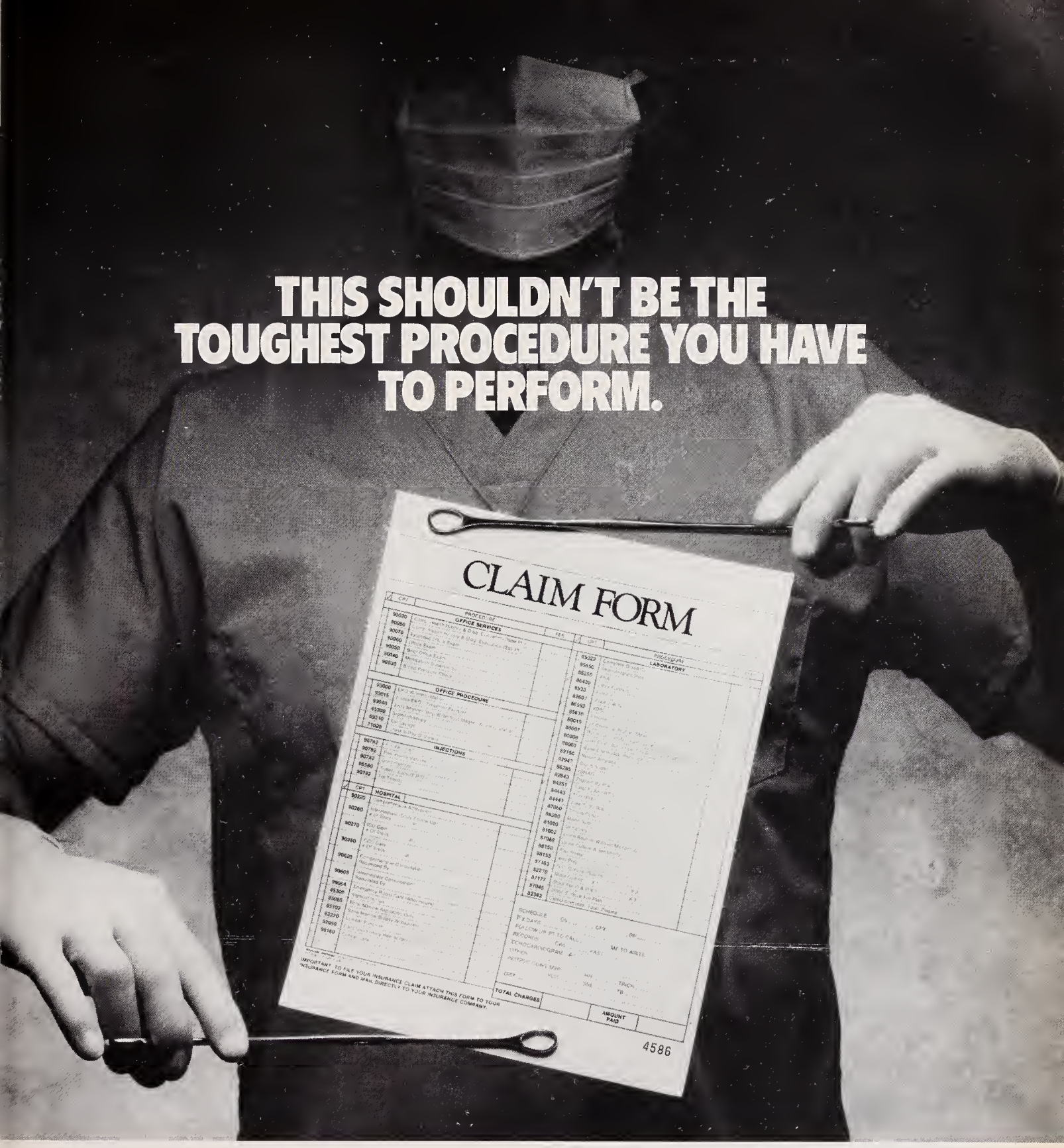


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# Physician and Counselor: Teamwork in Geriatric Care

**James K. Van Buren, M.D., Joe Whitwell, S.T.D.**

THE HEALTH OF MANY elderly people is acutely dependent on reestablishing and maintaining the delicate balance between the physical, emotional, social, and spiritual dimensions of life. As a physician and pastoral counselor, the authors have had the rare opportunity to work closely together at Wesley Woods Center in the assessment and treatment of older patients within the context of family and community. We want to share some of our observations, based on our experiences, in an effort to reinforce the importance of an interdisciplinary approach to geriatric care.

A primary observation is that the physical problem presented by the elderly patient is frequently not only a symptom of one or more medical conditions, but an indication also of overriding concerns about his or her life. The fear of dying, the helpless feeling of becoming more dependent, disappointment with one's life, unresolved grief, or concern over conflicts within the family are the major issues that affect physical health. Stress affects one's physical well-being, and the physical symptom can become the language for attempting to communicate deeper concerns.

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Since the physician is most likely to be called when the symptoms appear, he or she must be attuned to both the physical and emotional levels of the patient. Because older people experience multiple chronic problems and because many physicians cannot spend the time that some older patients require, a referral to a counseling resource can be a significant intervention. The physician can then treat the medical problems and the counselor can address the emotional issues in a mutually supportive manner.

Perhaps the best indicator that a referral is in order is the continuing somatic complaint after a medical evaluation reveals no medical problem or when complaints continue when treatment should be sufficient to relieve the symptom.

An observation that has been imprinted on us through years of working with geriatric patients is that all symptoms are valid and must be evaluated. We know that a patient of any age deserves an unprejudiced assessment, but it does happen that a physician will regard some complaints as part of aging. It is a mistake to dismiss symptoms simply because the patient is elderly. For example, low blood counts are often considered an age-related problem. Unless the patient is very old, there should be no drop in the blood count, and any anemia needs to be fully explained.

There are other areas, such as drug dosage, when there must be modification in treatment because of the age of the patient. The proper care and treatment of an older patient requires the physician's most attentive diagnostic acumen.

***Because older people experience multiple chronic problems and because many physicians cannot spend the time that some older patients require, a referral to a counseling resource can be a significant intervention.***

Another pertinent observation is the need to evaluate the potential effect of unresolved grief on the health of an elderly person. The cumulative effect of major losses — the home, family and friends, a job and its sense of independence — can intensify the grief reaction to such a degree that it adversely affects the patient's medical treatment. Of course, unresolved grief can lead to pathologic depression which is the biggest undiagnosed and untreated problem in the elderly. A physician's inclination may be to respond to depression with medication alone. Medication certainly has an appropriate role, but our experience is that counseling can be an effective intervention with the patient. Ignoring grief as a possible underlying problem often results in chronic somatic complaints.

Physicians may sometimes feel that counseling is not a realistic option for the elderly patient. Popular myth would have us believe that older people do not understand or use "therapy." Our observation has been the opposite. Though each situation is different, we find most older people willing or even eager to utilize a good counselor in talking through grief and loss, particularly in brief, problem-oriented counseling.

A third observation is that medical treatment and counseling are most effective when an open communication system among patient, family, and professionals can be established. When all the principals do not communicate with each other, three counter-productive tendencies develop. One is to ignore the patient and work directly with the family. Another is to patronize the patient. The third is to work with only one family member when several are involved in the patient's care.

There is a tendency to believe that older people cannot tolerate the truth. Therefore, a family may feel that the more caring attitude is to keep information from the patient. This happens frequently with patients who have terminal conditions. It has been our experience that it is better to keep the patient informed, if he or she is mentally capable of understanding. Withholding information often creates even more family conflict. A counselor can help key members of a family work through their resistance to an open communication system, if the physician can support the family to seek this kind of help.

***Popular myth would have us believe that older people do not understand or use "therapy." Our observation has been the opposite.***

A related family issue is that there is not always unanimity among the family members as to what the patient's problem is or how it should be treated. For example, three of the four children of an elderly patient may feel that their mother would be more effectively cared for in a nursing home. The fourth may believe that another family member should be providing care in the home. The older patient is caught in the middle of the conflict, and the family itself may need counseling to determine the best course of action.

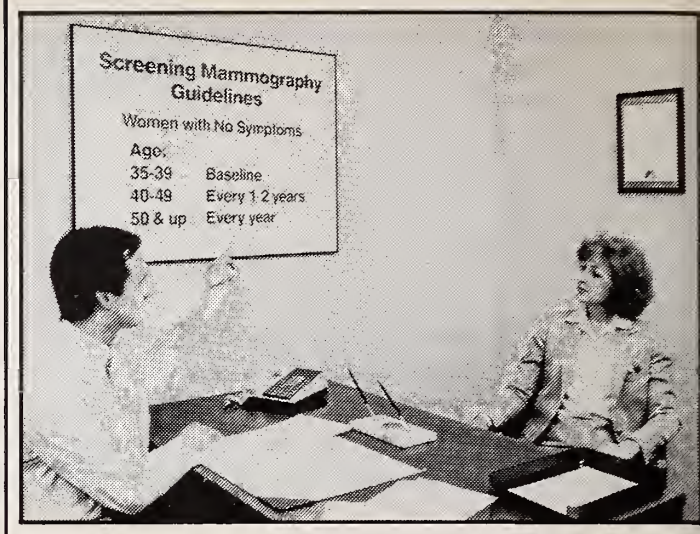
***Many patients would prefer that any and all problems be handled with medication. The fact is that medical care, particularly for the aged, is not that simple.***

Another reason to include all key family members in the treatment of older patients is that each individual family member frequently experiences the patient differently. Behavior and symptoms can change, depending on the nature of the relationship between family members. Each family member has a piece of the puzzle of the older patient's health. Without all of the pieces, the picture is incomplete.

There is a fine ethical balance to be struck between open communications and confidentiality and between an individual patient's right to self determination and the collective wishes of the family. It is our belief that the physician and counselor must listen to the patient first. The decision as to the patient's competence must be made, of course, but once he or she is deemed competent, it is the patient who should be given primary credence.

This is not to say that the patient may not have unrealistic ideas of what he or she wants. For example, a patient may want and expect an only child to physically take care of him, when the reality of the situation is that the child is not able to assume this responsibility. Counseling may help greatly in resolving such conflicts so that the patient get the needed care as expeditiously as possible.

It has been our experience, then, that many aspects of the elderly person's medical care are made easier through an interdisciplinary approach. Many patients would prefer that any and all problems be handled with medication. The fact is that medical care, particularly for the aged, is not that simple. When we have explained to patients that there is an aspect to their condition that can be managed through the interaction of counselor and physician, their response is usually one of relief. They are pleased to have their situation assessed and to know that there is a plan for their care. ■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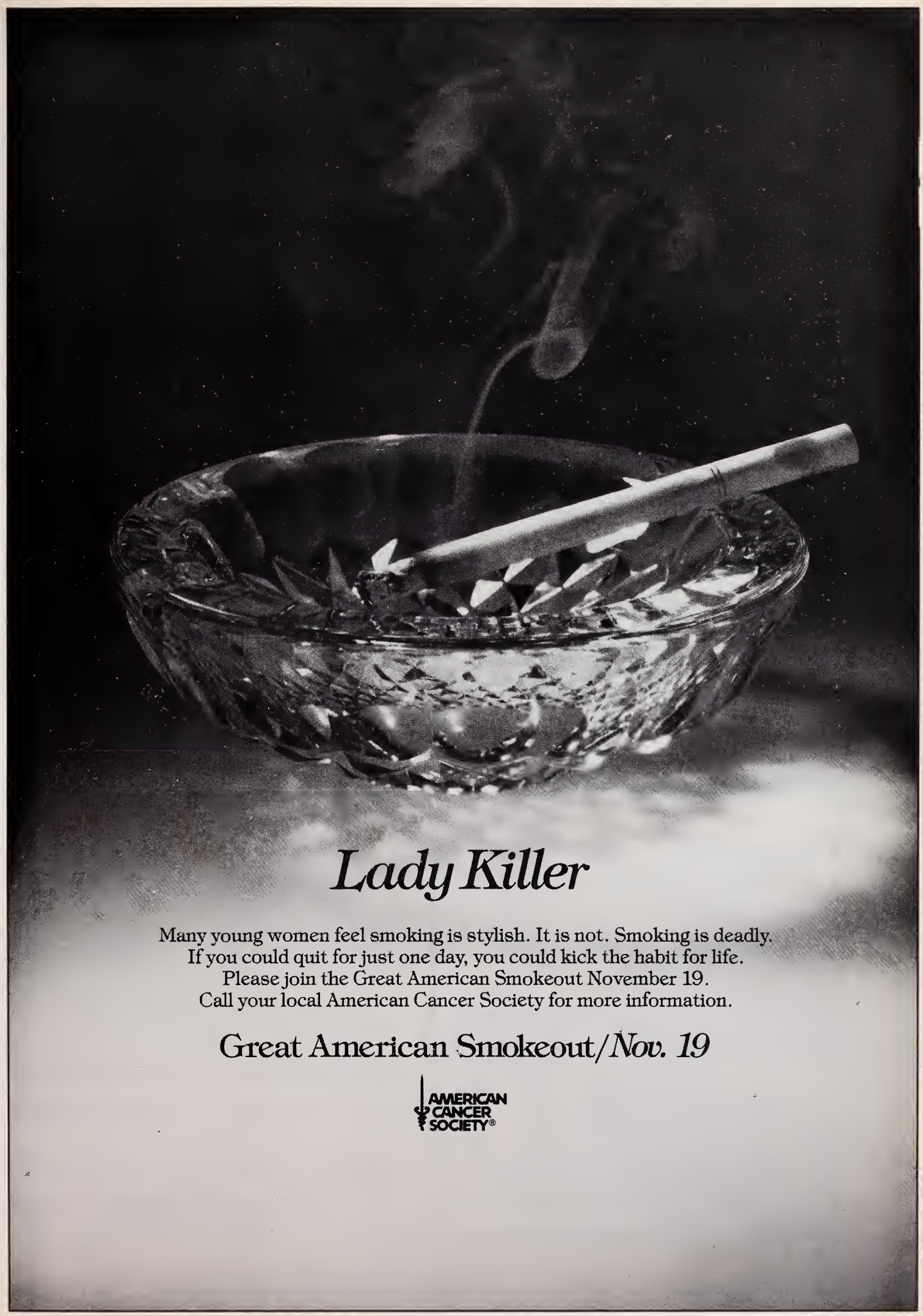

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**Pregnancy:** Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

**Pediatric Use:** Safety and effectiveness in children have not been established.

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**DOSAGE AND ADMINISTRATION**
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

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**References:**
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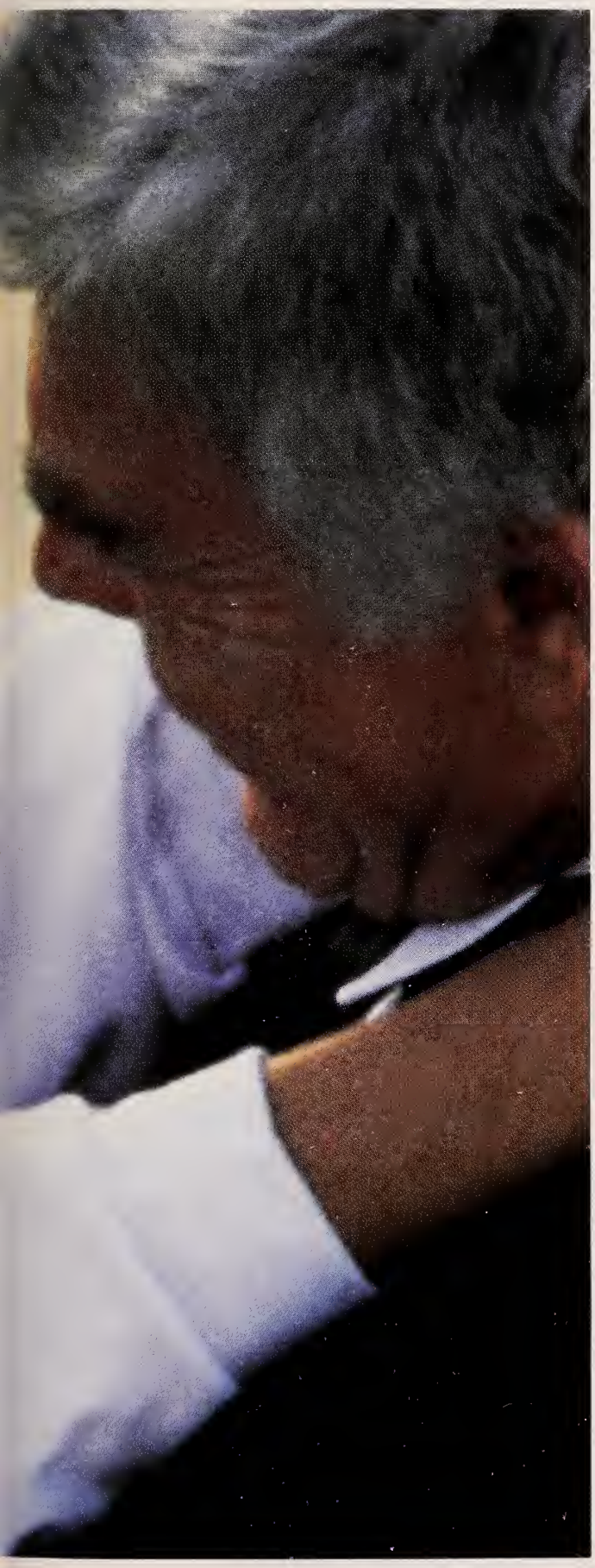

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2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.
The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimated a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

**DESCRIPTION:** PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

**INDICATIONS AND USAGE:** PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

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**CONTRAINDICATIONS:** Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (see Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

**WARNINGS:** Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning). However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

**PRECAUTIONS:** Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not yet complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, $T_4$ by column, or $T_4$ by radioimmunoassay. Free $T_3$ resin uptake is decreased, reflecting the elevated TBG; free $T_4$ concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration.

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

**ADVERSE REACTIONS:** The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis; change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria, edema; changes in libido.

**ACUTE OVERDOSAGE:** May cause nausea, and withdrawal bleeding may occur in females.

**DOSAGE AND ADMINISTRATION:**

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1. *Given cyclically for short-term use only.* For treatment of moderate-to-severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically:* Osteoporosis. Female castration. Osteoporosis —0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off). Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

**PREMARIN® Brand of conjugated estrogens Vaginal Cream**

*Given cyclically for short-term use only.* For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three- to six-month intervals.

Usual dosage range: 2 g to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

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# Arthroscopic Synovectomy in the Rheumatoid Metacarpophalangeal Joint

L. L. Wilkes, M.D.

***The intent of this paper is to acquaint those treating the rheumatoid hand with another option in those cases where conservative treatment has failed and to encourage others to improve and refine the technique of arthroscopic synovectomy in other joints.***

SYNOVECTOMY in rheumatoid joints is considered to be a reliable operation for the temporary relief of pain. However, the complication rate following open synovectomy is not insignificant. Because of its reduced morbidity, arthroscopic synovectomy has gained popularity in recent years. The procedure has proven itself in the knee, but it may be as applicable in the rheumatoid metacarpophalangeal (MCP) joint as demonstrated in this report.

### Materials and Methods

Patients in this study were adults with polyarticular rheumatoid arthritis unresponsive to non-operative treatment for over 3 months. All had significant pain and persistent synovitis, but patients were excluded if palmar subluxation or radiographic evidence of severe joint destruction was present.

The operative procedure was performed under regional anesthesia and under tourniquet control. All procedures were done on an out patient basis. A 1.7 mm needle arthroscope was used for visualization employing techniques previously described in the literature.[1] The joint was distended with saline as the 2 mm or 3 mm prototype suction-cutting instrument was used to remove the synovium. The arthroscope and cutter were alternately used in portals medial and lateral to the extensor tendon (Figure 1). Compression bandages were used for 24 hours followed by immediate range of motion exercises.

Dr. Wilkes practices orthopedic surgery. Send reprint requests to him at Chatham Orthopaedic Association, 44 Medical Arts Center, Savannah, GA 31499.

### Results

The procedure was performed on 13 joints in five patients. The average age was 43.6 years. The follow-up period ranged from 35 to 48 months and averaged 50.6 months (4.2 years).

During the follow-up period, the patients were categorized by the re-

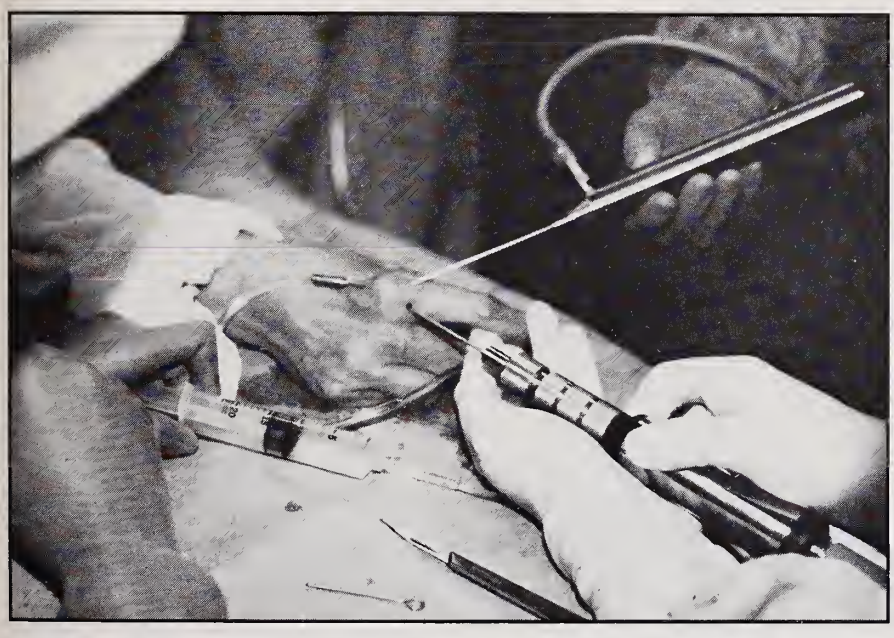

*Figure 1 — The 1.7 mm arthroscope and the 2 mm prototype suction cutter are shown in position.*

maining degree of pain and function, the range of motion, and by any radiographic changes. As expected, the latter two variables were not affected by the procedure. However, all the patients reported varying degrees of pain relief.

At the end of 2 years, three joints were rated "good" (minimal pain and minimal loss of function), six were "satisfactory" (mild to moderate pain and moderate loss of function), and three were "poor" (incapacitating pain and severe loss of function). As expected, the results deteriorated with time, and by the end of 4 years there were no "good," seven "satisfactory," and five "poor" results.

## Discussion

The anatomy of the rheumatoid MCP joint is remarkably similar to that of the knee. There is a large expanse of synovium superior to the joint under the extensor tendon much like the suprapatella pouch of the knee. As in the knee, synovium is concentrated under the collateral ligaments. Both of these areas are easily reached arthroscopically.

Synovectomy in a rheumatoid joint should be considered a procedure for the temporary relief of pain. It has been shown that the degree of pain relief diminishes with time,[2] that synovectomy has little effect on eventual joint destruction,[3] and that after two years the visual, histological, and enzymatic properties of the synovium are unchanged from their preoperative conditions.[4] However, one can still make a strong argument for arthroscopic synovectomy since the morbidity is so low, and there can be extended periods of pain relief.[5]

## Summary

This brief report establishes the feasibility and describes a technique for synovectomy of the MCP joint. It is not intended to be a definitive work on arthroscopic synovectomy. The intent is to acquaint those treating the rheumatoid hand with another option in those cases where conservative treatment has failed, and to encourage others to improve and refine the technique of arthroscopic synovectomy in other joints.

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*[The author wishes to thank Dyonics, Inc., for supplying the prototype instruments, many of which are now available, for use in this work. I especially wish to thank Gardner Gay, formerly with Dyonics, for his assistance and encouragement.]*

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# *Multiple Pulmonary Nodules With Pleuritic Chest Pain*

*Bruce Henschen, M.D., Bashir A. Chaudhary, M.D.*

Chest roentgenogram on admission.

## Clinical Presentation

A 20-year-old black woman presented with a 2-month history of nonproductive cough and pleuritic substernal chest pain radiating to the left shoulder. During these 2 months, the patient had one episode of streaky hemoptysis, malaise, and weight loss of 10 pounds. There was no history of night sweats, fever, or dyspnea. She had a 5-year history of smoking a pack of cigarettes daily.

Physical examination showed a thin, chronically ill appearing young woman. Vital signs were: blood pressure 110/60 mmHg, pulse 104 per minute, respirations 24 per minute, and temperature 102° F orally. There was no lymphadenopathy. Auscultation revealed late inspiratory crackles at both lung bases. A soft systolic ejection murmur at the base was present. The remainder of the physical examination was normal. Arterial blood gas analysis showed: pH 7.46, PaCO2 35 mmHg, PaO2 74 mmHg, O2 saturation 93%. Complete blood count and serum electrolytes were normal. Spirometry showed FVC of 1.68L (47% predicted) and FEV1 1.38L (47% predicted). The chest roentgenogram showed bilateral, multiple, fluffy nodular infiltrates (Figure 1). A PPD skin test was negative. A diagnostic fiberoptic bronchoscopic examination was performed.

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This paper was sponsored by the Georgia Thoracic Society.

Chest roentgenogram 4 months after therapy.

### Diagnosis and Treatment

Transbronchial lung biopsies from the right lower lobe showed noncaseating granulomas. Nodular pulmonary sarcoidosis was diagnosed. Special stains and cultures of the biopsy and bronchial washings showed no organisms. She was given 80 mg of prednisone daily with rapid improvement of her symptoms. Her chest roentgenogram showed near total resolution of the pulmonary nodules in 4 months (Figure 2). Prednisone therapy was later changed to alternate day therapy and gradually tapered.

### Discussion

Nodular pulmonary sarcoidosis (NPS) is an uncommon presentation of sarcoidosis, estimated as 2-4 percent of cases in two large series.[1, 2] Only 24 cases designated as NPS have been reported in the literature.[2-9] The clinical course and the response to therapy do not appear to be different from other forms of sarcoidosis.

The roentgenographic lesions are described as nodules 1 cm to 3-4 cm in diameter. The nodules usually have fluffy or hazy borders with coalesence of lesions, but occasionally have sharp and well circumscribed borders. After observation or treatment, the roentgenogram may either clear spontaneously or show a fine reticular interstitial pattern. Diffuse infiltrates may also appear. Hilar enlargement has been reported in the majority of cases.

As in classical sarcoidosis, patients often present with symptoms of cough with or without sputum production, dyspnea on exertion, weight loss, or pleuritic chest pain, or they may be asymptomatic. Uveitis, erythema multiforme, erythema nodosum, and arthralgias have been reported, as well as diffuse lymph node enlargement. Overall, the symptoms are mild. The clinical course is typically mild as well. Often, the chest roentgenogram pattern regresses spontaneously. Symptomatic patients have been treated with corticosteroids with improvement. There has been no reported progression to severe disability or end stage pulmonary fibrosis.

In the only series of patients to be followed with spirometry, restrictive disease was present initially in four of the five patients.[3] In spite of clearing of roentgenographic lesions, the restrictive changes remained unchanged or worsened. Four of the five had mild hypoxemia which remained stable or improved.

Reported cases have shown noncaseating granulomas by open lung biopsy, transbronchial biopsy, or fine needle aspiration biopsy. The resemblance of the chest roentgenographic manifestations to necrotizing sarcoid granulomatosis (NSG) has been described by many authors.[10-13] As necrotizing sarcoid granulomatosis has an identical course and prognosis as sarcoidosis, Churg has suggested that they are the same disease.[14] The distinction has been a histologic one, necrotizing sarcoid granulomatosis demonstrating masses of granulomas with necrotic central areas and a distinctive form of angitis. It is the extent of vasculitis and necrosis which has been dissimilar to classical sarcoidosis.

In a patient with multiple pulmonary nodules, the usual differential diagnosis includes infectious granulomatous disease (tuberculosis, fungal), immunologic lung disease (Wegeners, lymphoid granulomatosis, rheumatoid nodules), and tumors (metastatic, lymphoma, myeloma, solid tumors).

*(Continued on page 646)*

# Aspiration Cytology in the Evaluation of Breast Masses

*Charles M. Ferguson, M.D.*

CLINICAL EVALUATION of patients with breast masses usually produces uneasiness in both the patient and clinician. Though the actual incidence of breast cancer in a breast clinic is low — 6% in Haagensen's Series[1] — both the patient and clinician have this foremost in their minds. The patient is usually afraid she has breast cancer, while the physician is most concerned about not diagnosing a cancer which may be present. Though mammography is helpful in the diagnosis of breast masses, it is well accepted that it is associated with a 10 to 15% false negative rate,[2] and thus is a somewhat insensitive diagnostic tool.

We have found needle aspiration cytology to be a very helpful tool in the diagnosis of breast masses. Though excisional biopsy remains the gold standard for diagnosis of solid breast masses, we have found that aspiration cytology can reliably diagnosis cancer, and, perhaps more importantly, confirm a clinical diagnosis of a benign breast mass.

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This paper was sponsored by the Georgia Division of the American Cancer Society. Those wishing to contribute papers to the CANCER Section should send them to Thomas W. Phillips, M.D., CANCER Section Editor, 25 Prescott St., Atlanta, GA 30365.

**Table 1 — Reported Sensitivity of Fine Needle Aspiration of Breast Masses**

| *Author* | *No. of Cases* | *% Unsatisfactory* | *% Sensitivity* |
|---|---|---|---|
| Bell[5] | 1680 | 14 | 82 |
| Wanebo[6] | 398 | 10 | 72 |
| Kline[7] | 3545 | not stated | 66 |
| Bassett[11] | 3724 | 30 | 60 |
| Azzarelli[12] | 1138 | 32 | 65 |
| Franzen[4] | 3479 | 7 | 75.8 |
| Kreuzer[13] | 602 | not stated | 75 |
| Abele[8] | 92 | 0 | 88 |
| Kern[9] | 161 | 0 | 70 |
| Grady Hospital[14] | 86 | 20.9 | 73.7 |

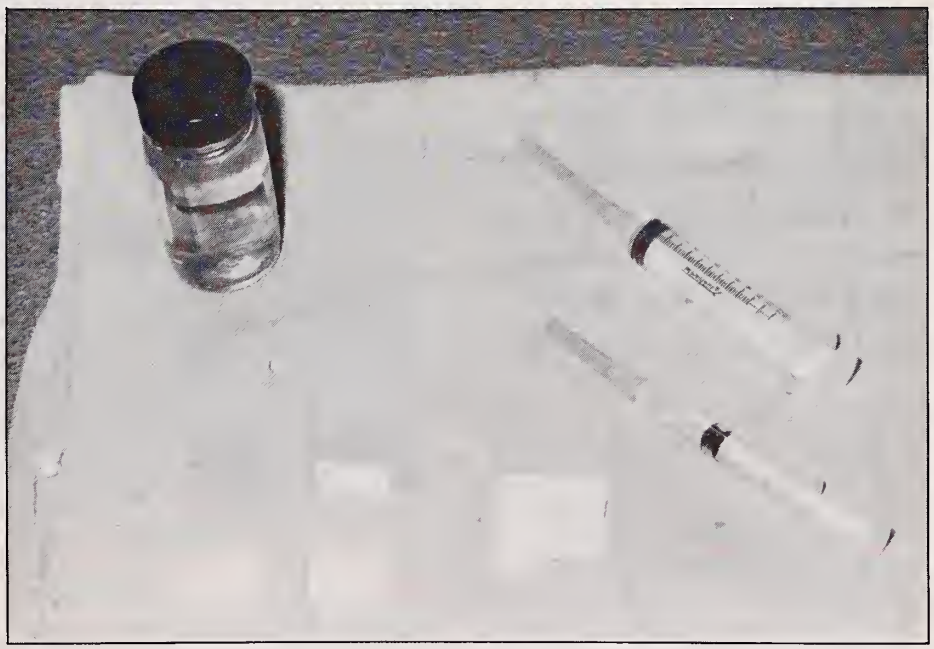

*Figure 1 — Equipment for aspiration cytology: 2 cc syringe with 25 gauge needle and 1% Lidocaine, 12 cc syringe with 21 gauge needle, and cytology slides and fixative.*

Numerous reports attest to the accuracy of aspiration cytology of breast masses.[3-13] Most of these reports are by pathologists with a particular interest in breast disease who examine the patient, review the mammogram, and perform the aspiration. Unfortunately, few clinicians have such a service available, and there is some concern as to the accuracy of aspiration cytology when the clinical evaluation and aspiration are not performed by the same individual who interprets the cytology. We recently examined our experience with aspiration cytology at the Breast Clinic of Grady Memorial Hospital,[14] and found results similar to those reported by other groups. All of our aspirations and clinical evaluations were performed by surgical residents and faculty, while the aspirations were interpreted by the cytopathology staff. Twenty-one percent of our aspirates were unsatisfactory, the sensitivity was 74%, and the specificity 100%. These figures compare favorably with other reported series (Table 1).

***"The major pitfall in aspiration cytology of breast masses is the unsatisfactory aspiration. Causes for this include air drying, insufficient cells on the slide, and a bloody smear."***

*Figure 2 — Fixation of mass with left hand.*

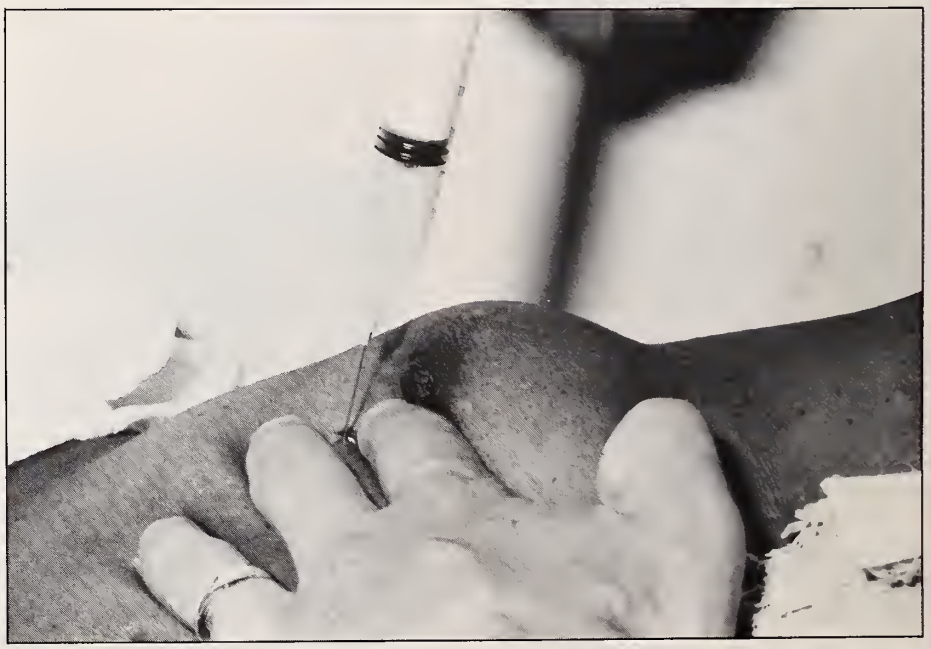

*Figure 3 — Aspiration of mass with 12 cc syringe and 21 gauge needle.*

The equipment necessary for performing aspiration cytology is shown in Figure 1.

To perform aspiration cytology, the index and long fingers of the left hand are used to immobilize the breast mass as the overlying skin and subcutaneous tissues are infiltrated with 1% Lidocaine (Figure 2). A 10 cc syringe with a 21 gauge needle is inserted into the mass, and full suction is applied as four to five passes are made through the mass (Figure 3). Suction is released and the needle withdrawn from the mass. The needle is then removed from the syringe, air drawn into the syringe, and the needle reconnected. The contents of the

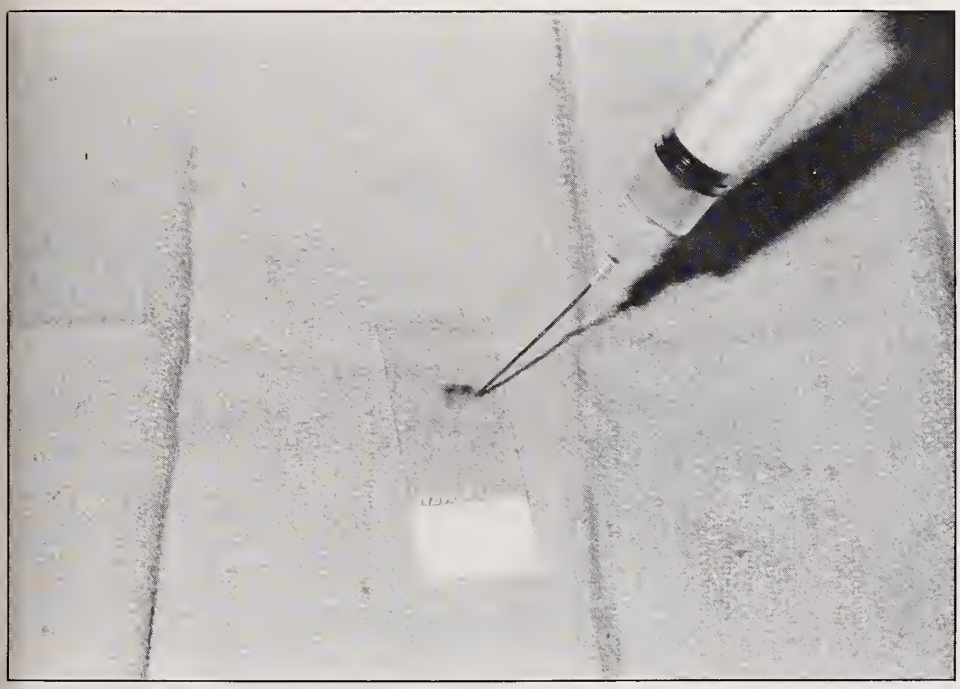

*Figure 4 — Preparation of slide.*

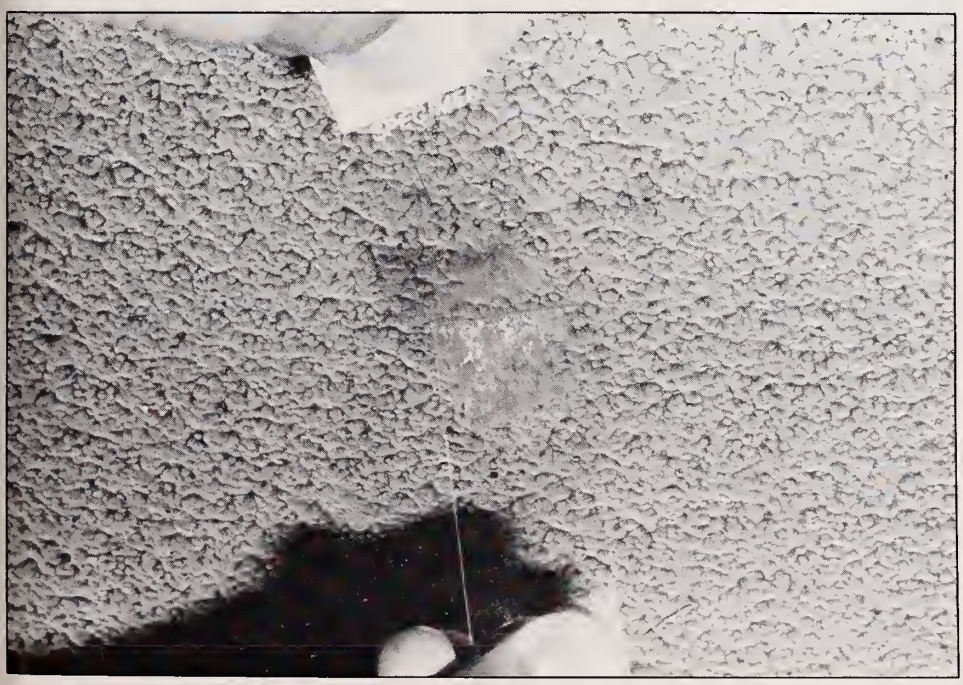

*Figure 5 — Spreading the smear.*

eedle are then quickly expelled onto a lass slide (Figure 4), smeared with a econd slide (Figure 5), and then laced in 95% alcohol fixative. The lides are later stained by the Papanicolaou method and examined by the cytopathologist.

The major pitfall in aspiration cytology of breast masses is the unsatisfactory aspiration. Causes for this include air drying, insufficient cells on the slide, and a bloody smear. Air drying alters cellular morphology and makes diagnosis difficult or impossible. To prevent this, the cytology slide must be dropped into fixative quickly, preferably within 5 seconds of smearing. Insufficient cells for evaluation usually occurs when the breast is very fibrotic. Often this may be overcome by using a smaller needle (25 gauge). There should always be some cellular debris visible grossly on the slide after fixation. If there is none, the slide should be discarded and the aspiration repeated. Regarding bloody aspirates form thick slides which are difficult to stain and interpret, we recommend they be discarded and the aspiration repeated.

***"Aspiration cytology is a helpful tool in the evaluation of breast masses but is not the gold standard for diagnosis. . . . Perhaps its greatest utility is in the evaluation of non-suspicious masses in patients with little risk of malignancy."***

Once an adequate aspiration cytology is obtained, one can make management decisions based on it. In our experience, there have been no false positives; thus, a cytologic diagnosis of cancer is virtual proof of cancer. This allows for early discussion of treatment options and eliminates the need for outpatient biopsy. Though we have been reluctant to perform mastectomy

without histologic confirmation of malignancy, we are able to perform biopsy, frozen section, and mastectomy at a single operation, a procedure we had previously largely abandoned.

In our experience, one third of patients with suspicious cytology have breast cancer. All of these patients should have excisional biopsy, which we generally perform in Outpatient Surgery. Should the excisional biopsy prove to be cancer, then the patient is later admitted for mastectomy or lumpectomy and axillary dissection.

***"There is some concern as to the accuracy of aspiration cytology when the clinical evaluation and aspiration are not performed by the same individual."***

Patients with benign cytologic aspirates generally have benign disorders. However, 12% of our patients with benign aspirates were later found to have cancer when excisional biopsy was performed. Again, this emphasizes that aspiration cytology is a helpful tool in evaluation of breast masses but is not the gold standard for diagnosis. Options for management of patients with benign aspiration cytologies include observation, repeat aspiration, and excisional biopsy. Management of a particular patient depends on the clinical situation (i.e., age, family history, physical and mammographic findings).

In conclusion, we recommend aspiration cytology to clinicians who commonly deal with breast disorders. Though it cannot be relied upon to absolutely exclude carcinoma, it is a good diagnostic tool with reasonable sensitivity and specificity. Perhaps its greatest utility is in the evaluation of non-suspicious masses in patients with little risk of malignancy. A benign cytology in this setting is comforting to both patient and clinician. The occasional malignant or suspicious cytology in this setting leads to an earlier diagnosis of breast cancer than would occur if the patient were simply observed, as commonly occurs. ■

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### *X-Ray Challenge*

*(Continued from page 642)*

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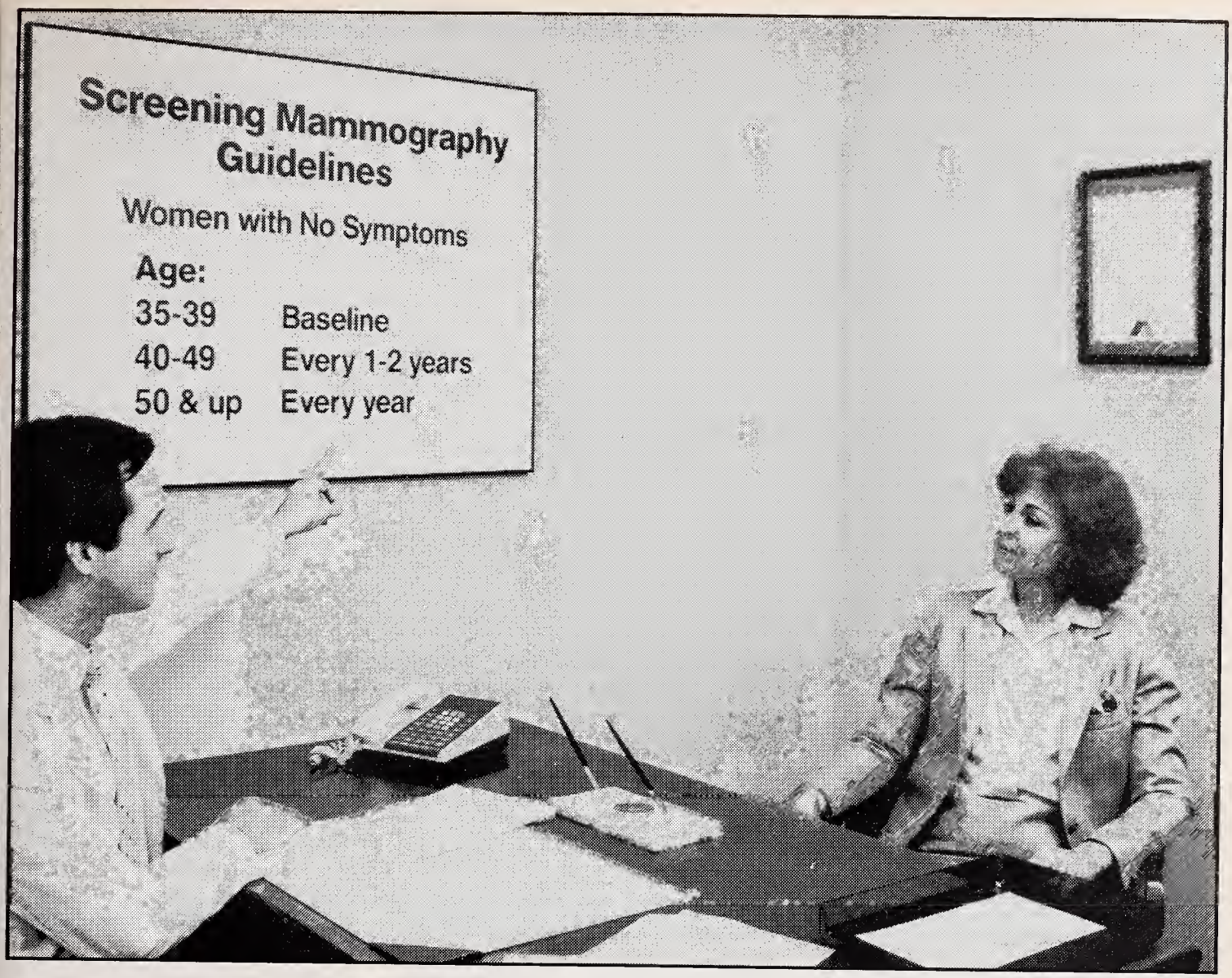


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# Abstracts From Symposium on Cardiovascular Research: Part III

*On August 8, 1986, the Georgia Affiliate of the American Heart Association held a symposium on Cardiovascular Research. More than 80 physicians and scientists from across the state gathered at the University of Georgia in Athens to present findings of research supported in part by contributions of Georgia residents. The following abstracts are representative of the research investigations discussed at this symposium and are the last of three parts presented in the HEART Section.*

VASCULAR POSTJUNCTIONAL ALPHA-1 AND ALPHA-2 ADRENOCEPTORS IN DIABETES.

R. E. White and G. O. Carrier, Department of Pharmacology and Toxicology, Medical College of Georgia, Augusta, GA 30912.

The aim of this study was to define the mechanism(s) responsible for the increased responsiveness of vascular smooth muscle to NE in diabetes. We examined 3 systems which play an integral role in the contractile effect of NE in mesenteric arteries from diabetic and age-matched control rats: 1) the contribution of alpha adrenoceptor subtypes 2) the role of the endothelium, and 3) the role of extracellular $Ca^{2+}$. The vascular effects of NE, selective alpha-1, and alpha-2 agonists were examined. These agonists induced contraction of isolated mesenteric arteries, which was markedly enhanced in diabetic rats. Endothelium removal did not abolish the observed contractile alterations. However, the enhanced responsiveness was associated with an increased influx of extracellular $Ca^{2+}$. These findings indicate that abnormalities of the vascular adrenergic system exist in short-term diabetes which are not attributed to endothelial cell processes, but are associated with enhanced alpha adrenoceptor-calcium ion channel activity.

VOLATILE ANESTHETICS DISRUPT MUSCARINIC RECEPTOR-G PROTEIN COUPLING IN RAT HEART.

R. L. Dennison, Jr., B. L. Anthony and R. S. Aronstam, Depts. of Pharmacology and Toxicology and Anesthesiology, Medical College of Georgia, Augusta, GA 30912.

The influence of halothane and enflurane (0.5-8%) on muscarinic receptor binding in rat atrium was studied using [$^3$H]methylscopolamine ([$^3$H]MS). Anesthetic-gas mixtures were blown over membrane suspensions for 20 min before and during binding assays. Halothane and enflurane at concentrations up to 8% did not affect [$^3$H]MS binding (dissociation constant, number of sites, or rate constants of association and dissociation). Carbamylcholine binding affinity for cardiac receptors was similarly unaffected. The ability of 5'-guanylylimidodiphosphate, a stable analogue of GTP, to lower carbamylcholine affinity, however, was greatly reduced in the presence of either anesthetic: The fraction of receptors displaying high affinity agonist binding was decreased by GTP from 0.64 to 0.43 in the absence, but only to 0.52 in the presence, of anesthetic. The diminution of the guanine nucleotide effect may reflect a stabilization of the receptor-G protein complex due to either a direct action on the receptor complex or to an alteration of the physical state of the membrane. It is also possible that the ability of the G protein to bind guanine nucleotides is affected by anesthetic agents.

CARDIOVASCULAR-ACTIVE SUBSTANCES FOUND IN MARINE INVERTEBRATES.

Pratibha Daftari and Pushkar N. Kaul, Department of Biology, Atlanta University, Atlanta, GA 30314.

The HEART Section is sponsored by the Georgia Affiliate of the American Heart Association. Those wishing to contribute articles to this Section should send them to Wesley Covitz, M.D., HEART Editor, Section of Pediatric Cardiology, Medical College of Georgia, Augusta, GA 30912.

Marine invertebrates have been ound to contain novel molecules ossessing various types of ardiovascular activities. These range om small molecules such as utonomium, which is a henethylamine congener with both pha and beta adrenergic as well as nolinergic activities, and ypotensive nucleosides to large olecules such as palytoxin of 3000 ol. wt. and several cardiotonic eptides containing 47-49 amino acid sidues.

More recently, we have been orking with a sponge of *Mycale* pp. the extracts of which upon actionation gave a fraction (F-007) xhibiting strong cardiotonic effects n the isolated perfused guinea pig eart. This activity is dose-dependent nd not blocked by the antihistamine etiamide and/or the beta blocker ropranolol. There also appears to be resent an antiarrhythmic activity in e cardiotonic fraction. Adsorption romatography of F-007 on acid umina column has yielded a artially purified material with 5-fold creased activity. Further attempts to olate pure cardiotonic compound(s) om this material is in progress.

OLOR DOPPLER LOWMAPPING — PROSTHETIC ALVES. S. T. McMillan and A. P. oganathan, School of Chemical Engineering, Georgia Institute of Technology, Atlanta, GA 30332.

The most recent advances in ultrasound technology that have combined two-dimensional imaging with quantitative Doppler techniques have resulted in the capability of providing *in vitro* as well as *in vivo* fluid velocity and turbulence profiles distal to cardiac valves.

*In vitro* pulsatile flow studies were conducted in an anatomically sized model of the left ventricle. An ultrasound color Doppler flow mapping (CDFM) system was used to study the flow fields created by caged disc, caged ball, tilting disc, bileaflet and trileaflet mitral valves.

The results of the CDFM studies revealed that the axial velocity fields and the turbulence profiles distal to the valve prosthesis were quite dependent on valve design.

The use of non-invasive CDFM has provided semi-quantitative information as to these velocity and turbulence profiles. These *in vitro* investigations have also generated finger print color flow maps that will be extremely valuable for future clinical studies, and in the non-invasive follow-up of prosthetic valve patients.

NUMERICAL CARDIOVASCULAR STUDIES. F. Williams and A. P. Yoganathan, School of Chemical Engineering, Georgia Institute of Technology, Atlanta, GA 30332-0100.

In order to supplement *in vitro* studies, a computational modeling effort was started in 1982. This resulted in a steady turbulent flow computer model for stenoses and aortic valve geometrics in 1984. Since then, we have been investigating algorithms which could incorporate the unsteady nature of flow through heart valves.

Numerical models allow the study of cardiovascular flow fields in regions where LDA data is hard to get or unobtainable. One example is the central flow region through a tissue valve where high shear stresses can occur and possibly damage blood cells or the valve leaflets. In addition, LDA data can only be obtained at discrete points in a flow field. A numerical model gives a picture of the overall flow field. This is very useful for studying regions of high and low bulk shear.

We will present numerical results for steady flow through 2-D stenotic aortic valve geometries and compare them with experimental measurements of pressure, velocity and 2-D R.M.S. velocity. The necessity of accounting for the unsteady nature of the flow and efforts in this direction will be discussed.

PHENOTYPIC ANALYSIS OF MONONUCLEAR CELLS CULTURED FROM HUMAN CARDIAC BIOPSIES POST CARDIAC TRANSPLANTATION.

A. Ahmed, A. Leatherbury, W. Knopf, D. Murphy and K. W. Sell, Emory University School of Medicine, Atlanta, GA 30322.

Besides clinical symptoms, the current diagnosis of rejection in cardiac transplants relies on histological evidence of mononuclear cell infiltrates in cardiac biopsy tissues. Acute myocarditis also appears histologically to be similar. It is hypothesized that in both cardiac rejection episodes and acute myocarditis the lymphocytic infiltrates are involved in inducing myocyte damage and subsequent cardiac pathology. In effort to study the nature of these infiltrating cells, we have cultured *in vitro* biopsy tissue from patients post caradiac transplant in the presence of interleukin-2 (IL-2) which allows for the expansion of these cells in quantities sufficient to allow for phenotypic and functional characterization. A total of 125 such biopsies have been cultured *in vitro*. Sixty-two out of one hundred twenty-five resulted in cell growth. Twenty-five of these expanded cells were phenotypically analyzed using flow microfluorometry and monclonal reagents that define human T, B, NK cell, monocyte and T cell activation markers. The data indicate that 16/25 (64%) were predominately OkT4$^+$ and 9/25 (36%) were Leu-2$^{a+}$. A great majority of these cells (90%) were HLA-DR$^+$ and 4/25 showed 30% cells positive for VLA-1 (chronic T cell activation) and 17/25 showed cells 30% positive for Ta1-RD1 (acute T cell activation). Very few cells bearing NK cell markers (5%) were seen. No correlation was seen in the clinical status of the patient and the frequencies of OkT4$^+$ or Leu-2$^{a+}$ bearing cells. All cell cultures exhibited production of IL2 and macrophage stimulating factors to varying degrees. The functional role of these cells in cardiac tissues will perhaps allow for a more precise definition of cardiac rejection episodes.

PREISCHEMIC ENERGY ENHANCEMENT IN HYPERTROPHIED MYOCARDIUM.

J. D. Sink, M. S. Soberman, G. C. Forest, BA, C. R. Hatcher, Jr.

Increased susceptibility of hypertrophied myocardium to ischemic injury has been noted clinically and experimentally. Previous studies have demonstrated in the rat, canine, and human hypertrophied hearts that high energy phosphate content (ATP) is lower than that found in normal hearts prior to ischemia. In this study, oxygenated fluorocarbon cardioplegia (FC) was given to isolated hypertrophied rat hearts (SHR) to determine if ATP stores could be increased prior to the onset of ischemia. One group of SHR received 2 minutes of preischemic perfusion with FC and another group of SHR received 15 minutes of FC. (N = 8, Mean ATP umoles/g. dry wt. ± SEM, * = $p < 0.05$).

| NL Control | SHR Control | SHR 2″ | SHR 15″ |
|---|---|---|---|
| 19.6±0.6 | 16.2±0.7* | 19.3±1.1 | 19.6±0.8 |

These results indicate that ATP in hypertrophied myocardium can be increased prior to the onset of ischemia with perfusion of FC. Fluorocarbons with their unique oxygen dissociation properties are potentially ideal for cardioplegic agents.

MODULATION OF OUABAIN EFFECTS ON VENTRICULAR REFRACTORY PERIOD BY ADRENOCEPTORS.

C. M. Mokler. Cardiovascular Pharmacodynamics Lab, College of Pharmacy, University of Georgia.

Ouabain shortens the effective refractory period (ERP) of rabbit ventricle in a dose-dependent manner, an effect which may be related to the generation of toxic arrhythmias. This work examined the influence of selective adrenoceptor blockade on this effect of ouabain. Isolated rabbit hearts were given ouabain ($2 \times 10^{-8}$M to $10^{-7}$M) alone or after drugs which produced selective blockade of adrenergic receptors. Drugs used were metoprolol ($B_1$), butoxamine ($B_2$), prazosin ($\alpha_1$) or yohimbine ($\alpha_2$). Metoprolol had no effect on ERP but blocked the ouabain-induced shortening. Butoxamine and yohimbine had no effect on ERP or ouabain action. Prazosin increased the ERP but did not prevent the shortening induced by ouabain. These preliminary results suggest 1) that the release of norepinephrine from adrenergic nerve terminals is important in the action of ouabain on ventricular refractory period, and 2) that myocardial $B_1$ and $\alpha_1$ adrenoceptors play an important role

ı modulating this action of ouabain
n myocardial electrophysiology.

EMODYNAMIC CHANGES IN
HICK EMBRYOS PRECEDE
EART DEFECTS AFTER
ARDIAC NEURAL CREST
BLATION. D. E. Stewart,[1] M. L.
irby[1] and K. K. Sulik.[2]
epartments of Anatomy, Medical
ollege of Georgia,[1] Augusta, GA
0912 and University of North
arolina,[2] Chapel Hill, NC 27514.

Neural crest cells contribute to the
ormal architecture of the heart and
ortic arch arteries. Ablation of
eural crest cells over somites 1-3 in
ıe chick embryo prevents
onotruncal septation and results in
ersistent truncus arteriosus. We
ıeasured dorsal aortic blood velocity
nd vitelline artery blood pressure in
sioned and control embryos at a
eriod of cardiac morphogenesis
rior to septal formation. The
ıternal diameters of the dorsal aorta
t the level of the sinus venosus and
ıe aortic arch arteries at their
ıidpoints were measured in stage 18
mbryos. Lesioned embryos had
reater dorsal aortic blood velocity
nd lower systolic and diastolic blood
ressures than control embryos.
here was no difference in heart rate,
orsal aortic diameter or internal
iameter of the aortic arch arteries
etween lesioned and control
mbryos. Scanning electronic
ıicrographs revealed no gross
ifferences in caradiac looping or
onotruncal wall development
etween lesioned and control
mbryos; however, embryos with
blations developed hypoplastic 4th
haryngeal arches. This suggests that
emodynamic changes precede heart
efects in embryos with cardiac
eural crest ablations.


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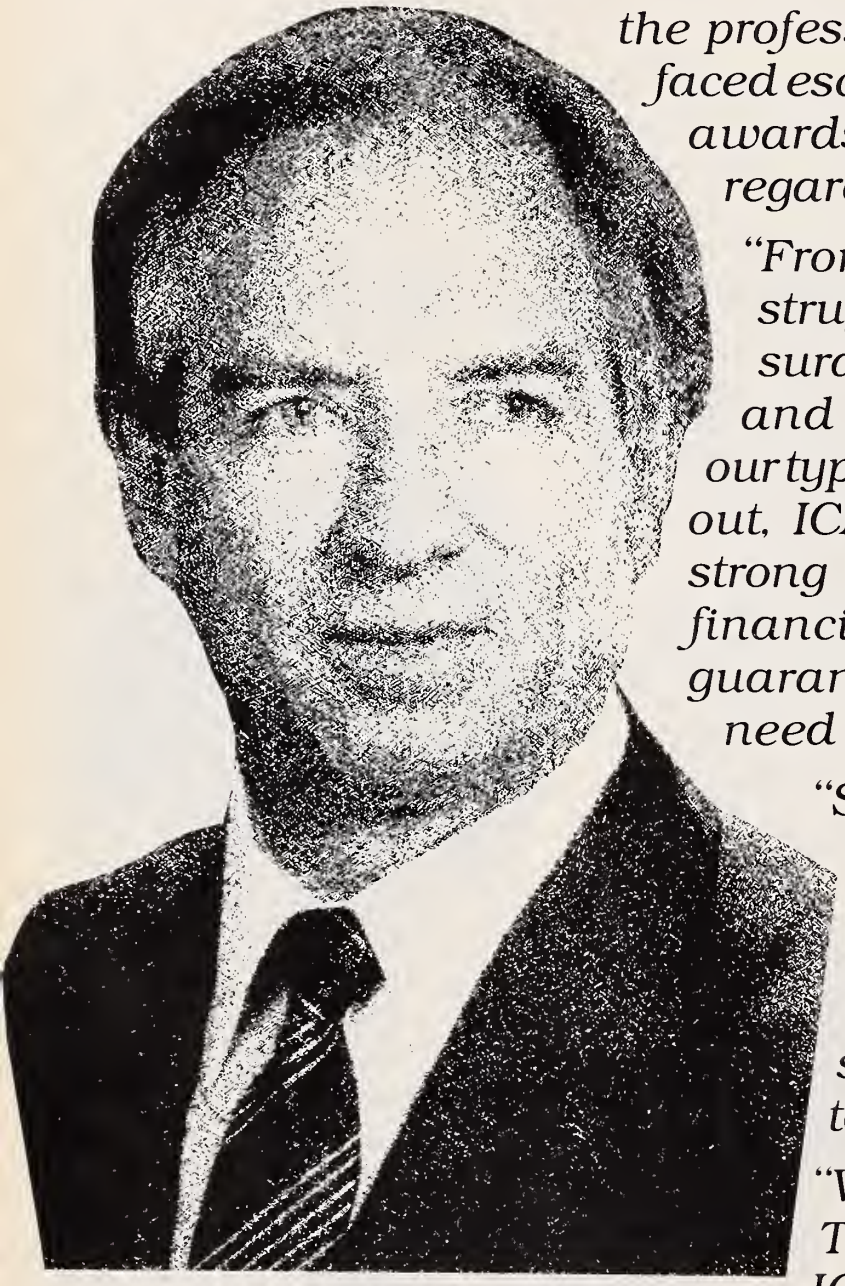

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The Medical Association of Georgia invites all state specialty societies to plan scientific meetings under the MAG "umbrella," and this year we have thirteen different specialty groups working with us. For each participating society, a program chairman selects topics and arranges speakers. The staff of the MAG coordinates publicity and registration and makes arrangements for meeting rooms, audiovisual needs, coffee breaks, etc. From registration fees received, the MAG in turn helps societies pay for their speakers.

This, fall, the Scientific Assembly of the Medical Association of Georgia will again meet in Atlanta at the Ritz-Carlton Buckhead Hotel. Our scheduled dates are November 20-22 (Friday-Sunday). Thirteen specialty programs will be presented during the weekend, each of which will be accredited for AMA Category 1 hours and other specialty credit designations.

Program chairs for the 1987 MAG Scientific Assembly, responsible for arranging these excellent CME sessions, are:

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CHEST DISEASE
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*Georgia Chapter, American College of Surgeons*
Robert Gongaware, M.D., Savannah

### Registration

Registration for the Scientific Assembly allows a physician to attend any and all CME programs held during the weekend. To register for these scientific meetings, please complete the registration form inserted in this *Journal*, detach it from the hotel reservation form, and mail it with your registration fee to the MAG office.

### Registration Fees

| | *MAG Member* | *Non-Member* |
|---|---|---|
| PHYSICIAN | | |
| Surgery Program only | $135 | $175 |
| Other specialty programs | $ 80 | $125 |
| RESIDENT PHYSICIAN | No fee | $ 15 |
| MEDICAL STUDENT | No fee | $ 10 |
| (OTHER HEALTH PROFESSIONAL — $40) | | |

### Hotel Accommodations at the Ritz-Carlton

If you wish hotel accommodations, please complete and detach the bottom portion of the registration form and mail it directly to the Ritz-Carlton Buckhead Hotel by October 29. Reservations will be held until 6 p.m. unless guaranteed or covered by deposit.

### The Weekend at a Glance

Complete details for all specialty programs will be printed in next month's *Journal*. For now, we attach an overview of the Scientific Assembly weekend.

### For More Information

Please call Steve Davis, Director of Education, at MAG's Atlanta headquarters, 866-7535 or 800/282-0224 (toll-free in Georgia).

And we'll see you at the Scientific Assembly! ■

# The Weekend at a Glance
# MAG 1987 Scientific Assembly
# November 20-22, 1987
# Ritz-Carlton Buckhead Hotel
# Atlanta

| FRIDAY NOVEMBER 20 | | SATURDAY NOVEMBER 21 | | SUNDAY NOVEMBER 22 | |
|---|---|---|---|---|---|
| Morning | Afternoon | Morning | Afternoon | Morning | Afternoon |
| | ALLERGY 12-5:30 | | | | |
| CHEST DISEASE 9-5 | | CHEST DISEASE 9-1 | | | |
| | | EMERGENCY MEDICINE 8-12:30 | | | |
| | | NEUROLOGY 9-3 | | | |
| | | NEURO-SURGERY 8:30-12 | | NEURO-SURGERY 8:30-12 | |
| | OB/GYN 1-5 | | | | |
| | | OPHTHALMOLOGY 9-5 | | | |
| | | | | ORTHOPAEDICS 9-3 | |
| OTOLARYN-GOLOGY 9-12 | | | | | |
| | | PATHOLOGY 9-4 | | PATHOLOGY 9-1 | |
| | | PLASTIC SURGERY 9-2:30 | | | |
| PSYCHIATRY 9:15-3:45 | | | | | |
| SURGERY 9-5 | | SURGERY 9-5 | | | |

# "High Quadriplegia– The Ultimate Challenge"

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A medical symposium addressing the acute and rehabilitative care of the C-1 through C-4 high quadriplegic. Hosted by Shepherd Spinal Center in Atlanta, now the nation's largest dedicated spinal cord injury hospital. Issues to be investigated include: medical, psychosocial and high tech approaches to care and rehabilitation. Special emphasis on ventilator weaning, the interdisciplinary care approach, phrenic nerve pacer implants and community reintegration.

## *Symposium Preview:*

### *High Quadriplegics: They Can Go Home Again*

With high quadriplegics surviving at unprecedented rates, quality of life issues and discharge planning are of paramount importance from the first day of admission to the specialty setting. The philosophy of treatment at SSC will be covered, including the referring physician's role in long-term medical management.

### *Medical Overview: Care of the High Quadriplegic*

The potential for complications such as deep vein thrombosis, stress ulceration, decubitus, pneumonia, urinary tract infections and sepsis poses a serious threat to high quadriplegic patients. Prevention strategies, the benefits of early mobilization of ventilator dependent patients and medical management of complications are covered.

### *Ventilator Weaning*

All high quadriplegics at Shepherd Spinal Center are evaluated to determine their candidacy for phrenic nerve pacer implants and their potential for weaning from mechanical ventilation. The pulmonary evaluation studies performed at SSC and protocols for weaning are included.

## *Panel and Concurrent Session Topics:*

- Pulmonary Issues
- Social Work: Discharge Planning, Peer Support, Sexuality
- The Therapeutic Value of Sensory Experience
- The Biofeedback Program at SSC
- Ventilator Home Care
- Focus On: Phrenic Pacer Implantation
- Departmental Presentations by O.T., P.T., Recreation Therapy, Social Worl Respiratory Care, Education, Nutritionists
- Emphasis on specialized equipment

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***High Quadriplegia– The Ultimate Challenge***

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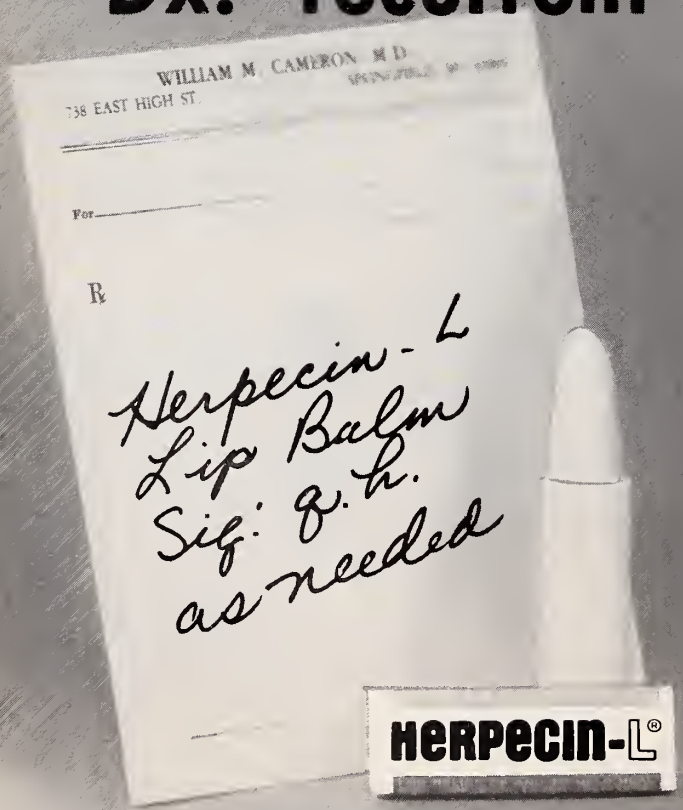


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# ADVERTISING INDEX


American Cancer Society ..... 614, 634, 647

Atlanta Magnetic Imaging ..... 640

Ayerst Laboratories ..... 628A-D, 636B-D

Blue Cross/Blue Shield ..... 631

Campbell Laboratories ..... 658

Citizens and Southern National Bank ..... 598

Classified Ads ..... 659

Clinical Opportunity for Smoking Intervention ..... 605

Diversified Auto Leasing ..... 630

Family Practice Recertification ..... 658

Health Quip, Inc. ..... 636

Insurance Corporation of America ..... 652

Lilly, Eli & Company ..... 612B

MAG Mutual Insurance Company ..... 596

Marion Laboratories ..... 604A-B, 636, 636A

Medic Computer Systems ..... 597

Roche Laboratories ..... 661-662

Shepherd Spinal Center ..... 656-657

St. Jude's Children's Hospital ..... 651

Upjohn Company ..... 612A

U.S. Army ..... 637

Weight Watchers of Greater Atlanta ..... 636

Wesley Woods Geriatric Teaching and Research Hospital ..... 600

Woodridge Hospital ..... 640


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**MANUSCRIPTS** — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

**STYLE** — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

**NEWS NOTES** — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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The Wesley Woods Geriatric Hospital is staffed and designed to address the complex physical, social, emotional and spiritual needs of the elderly. Outpatient services include a comprehensive health evaluation with the availability of medical specialists. Inpatient treatment units include an Alzheimer's Disease/Dementia Unit, a Psychiatry Unit, a Medical Unit and an Assessment Unit.

The Wesley Woods Hospital doesn't look like a hospital. Overlooking Peachtree Creek in a wooded setting, everything about the hospital, from the gray and white New England style exterior, to the warm peach-colored interior, is designed around one theme—the comfort and care of our patients and families.

The hospital is part of the Wesley Woods Center. The Center offers a variety of services to older people and their families including residential retirement living, intermediate care and skilled nursing care, respite care, Alzheimer's Disease care, family consultation and family counseling.

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Wesley Woods Hospital services are provided without regard to race, creed, color, national origin, handicap condition or age. Certified to participate in Medicare or Medicaid. Call (404) 728-6380 for further information.

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# CONTENTS

**VOLUME 76, NUMBER 10**

## FEATURES

HEALTH MAINTENANCE FOR YOUR MONEY 683
By David E. Thompson

FINANCIAL PLANNING: ARE YOU GETTING THE REAL THING? 687
By Gregg W. Schuder

THE PRACTICAL MATTERS OF PRACTICING MEDICINE 689
By Joyce Divinyi

THE MEDICAL PROFESSIONAL AS AN INDIVIDUAL INVESTOR: OFTEN MISUNDERSTOOD AND FORGOTTEN 691
By Brion D. Friedman

RETIREMENT: IS IT FOR YOU? 695
By John M. Hodges, M.D.

THE WAY IT IS 697
By Ward Pafford, Ph.D.

COMMON TECHNIQUES FOR OVERPAYING ESTATE TAXES 703
William C. Griffith, Jr., Don L. Waters

LEGISLATIVE REMEDIES TO THE LIABILITY CRISIS 707
By Charles D. Hollis, Jr., M.D.

MAG SCIENTIFIC ASSEMBLY 713

## EDITORIAL

AMA TO MEET IN ATLANTA 675
By Harrison L. Rogers, Jr.

## DEPARTMENTS

NEWS CAPSULES 668

PHYSICIAN'S RECOGNITION AWARD RECIPIENTS 672

CALENDAR 673

EDITOR'S CORNER 674

PRESIDENT'S PAGE 677

ASSOCIATION NEWS 678

REMEMBERING C. L. AYERS, M.D. 681

INDEX TO ADVERTISING/MANUSCRIPT INFORMATION 728

## COVER

Photograph by Luis Bigit, of Rogers and Bigit, Atlanta.

## *First Annual Physician/Legislator Golf Classic*

THE FIRST ANNUAL Physician/Legislator Golf Classic was held August 27 at Port Armor Golf and Tennis Resort on Lake Oconee. The format of the tournament involved foursomes comprised of one State Legislator and three physicians. There were approximately 72 attendees, and 16 foursomes received prizes ranging from vacations, televisions, cameras, Falcon tickets to fishing rods and a gorilla head cover. Special prizes for Longest Drive, Shortest Drive, Closest to the Pin, Most Golf Balls Hit Into Water, etc. were presented by State Legislator George Green, M.D. (the only physician serving in the Georgia Legislature).

*(L-R) Dr. J. Donald Fite, Rusty Kidd, State Representative Charles Bannister, Dr. James Leonard, Dr. Jack Menendez, and Dr. Thomas Grillo. Rep. Bannister and Drs. Fite Leonard and Grillo won First Prize which was a vacation package at a Hyatt Hotel in Hilton Head, Orlando, Sarasoto, or Cyprus.*

*(L-R) MAG President Menendez, State Senator Frank Albert, Dr. Stephen Brown, and Dr. S. Allan Stocks. Sen. Albert and Augusta Drs. Stocks, Brown, and Earl Dupree (not shown) won Last Prize for their efforts at the First Annual Physician/Legislator Golf Classic. The prize was a fishing rod. Dr. Menendez urged them to give up golf and take up fishing.*

R) MAG President Jack Menendez and U.S. Senator Al re.

*U.S. Senator Al Gore (left) spoke at MAG's Legislative Seminar. Also shown (L to R) are James A. Kaufmann, M.D., Chairman, MAG Council on Legislation; State Senator Pierre Howard; and Jack Menendez, M.D.*

## *Presidential Candidate Gore Speaks*

URING THE 1987 MAG Legislative Seminar, attended 18 State Representatives and State nators, along with 170 MAG mbers and spouses, the featured aker was U.S. Senator Al Gore, mocratic candidate for the sidency of the United States. Dr. Jack Menendez, President of AG, hosted a luncheon for Senator re following his talk, and many endees of the seminar seemed orably impressed by the positions ator Gore stated on numerous es pertaining not only to dicine but also to national affairs.

## *Hospitals Designated As Heart Transplant Hubs*

THE LIST OF Medicare-approved heart transplant centers was expanded to seven with the designation of five additional hospitals last August.

The additional facilities are: Foster G. McGaw Hospital, Loyola University Medical Center, Maywood, IL; University of Minnesota Hospital and Clinic, Minneapolis; University Medical Center at the Arizona Health Sciences Center, Tucson, AZ; Johns Hopkins Hospital, Baltimore, and Methodist Hospital and Baylor College of Medicine, Houston. Medicare approved the Medical College of Virginia at Richmond and Stanford University Medical Center, Stanford, CA, last July.

Approval is retroactive to Oct. 17, 1986, when Medicare selection criteria were published in the Federal Register.

*(Reprinted from AHA News, Vol. 23, No. 32, Aug. 17, 1987.)*

## AMA Workshop Explains How To Obtain Fair Reimbursement

"INSURANCE PROCESSING AND CODING for the Medical Office," an AMA workshop, helps physicians ensure that they receive fair reimbursement from third-party payors.

Designed for medical office staff and business managers, this valuable, one-day workshop helps participants acquire a working knowledge of Current Procedural Terminology through "hands-on" practice. Participants will also learn important facts about third-party payors, and methods of efficiently tracking outstanding claims. Workshop participants will receive a copy of the "Insurance Processing and Coding" workbook which contains many helpful forms and charts, and a current edition of the CPT-4 coding manual at no additional charge.

The workshop is conducted by staff of the AMA's Department of Practice Management, whose lively teaching style and indepth knowledge of medical practice management has helped make Practice Management workshops popular among physicians and medical office staff nationwide.

The workshop will be conducted from 8:30 AM to 4:30 PM in Atlanta, GA on January 21, 1988. Fee is $175 for AMA members, $195 for nonmembers, and includes refreshment breaks and workshop materials.

To register, or for more information, call the AMA Practice Management Registrar collect at (312) 645-4958, or write to the American Medical Association Department of Practice Management, 535 N. Dearborn Street, Chicago, IL 60610; Attn: Registrar.

One tactic that has proven to be effective in keeping nurses professionally satisfied is the clinical "ladder" program established by Boston's Beth Israel Hospital. The program allows nurses to advance through six clinical levels — or "ladders" — that recognize increased expertise with matching salary hikes. The result: a nurse-vacancy rate averaging about 3 percent — well below the state average.

*(Reprinted from AHA News, Vol. 23, No. 32, Aug. 17, 1987.)*

## Analysts See "Signs of Life" In For-Profit Multis

REPORTED EARNINGS for investor-owned multi-hospital systems for the second quarter of 1987 mark the beginning of an upward trend, according to analysts, although some declines are still being reported. American Medical International (AMI), Beverly Hills, CA, reported 1987 second-quarter earnings of $31.7 million — which is up 47 percent compared to earnings during the same quarter in 1986.

"We're still seeing some declines based on where (some of the systems) are in their restructuring, but the earnings declines of the mid-1980s are behind the industry," said analyst John F. Kindelong of Smith, Barney, Harris, Upham, & Co., New York City.

Declines in earnings reported by the Hospital Corporation of America (HCA), Nashville, TN, continued to moderate. Earnings of $61.3 million for the quarter were down 11 percent compared to the same period of the previous year. But Hindelong expects HCA's earnings to improve, following its proposed sale of 104 hospitals to HealthTrust Inc., an employee stock-management plan.

Louisville, KY-based Humana Inc. reported flat earnings of $52.3 million, which Hindelong characterized as encouraging because the company is still suffering substantial losses on its CarePlus health insurance subsidiary.

National Medical Enterprises (NME), Los Angeles, reported a loss of $35.9 million for the 3-month period. The company attributed the loss to a $72.8 million write-off of businesses that were discontinued as part of the company's year-long restructuring. Marg L. Vignola, an analyst with Salomon Brothers Inc., New York City, said NME's restructuring was wise and the company's earnings "will be steadily up from here." Restructuring activity as well as stabilization in admission trends were major factors in improved earnings for the industry overall, Vignola added.

*(Reprinted from AHA News, Vol. 23, No. 32, Aug. 17, 1987.)*

## JCAH Names Task Force on Management Quality

THE JOINT COMMISSION on Accreditation of Hospitals (JCAH), Chicago, named members to a task force to develop indicators of quality in hospital management and governance. The Organization and Management Indicators Task Force will seek to identify characteristics that relate to quality of care. Those characteristics will be incorporated into the JCAH's new accreditation process, scheduled to be implemented in 1990. The task force also will develop indicators of quality for management in nursing homes, hospices, psychiatric facilities, and ambulatory care settings.

*(Reprinted from AHA News, Vol. 23, No. 32, Aug. 17, 1987.)*

## ew AMA Workshop Takes The Mystery Out of Physician Contracts

'EVALUATING CONTRACTS,'' a new AMA workshop, helps ysicians to read, analyze, and pond to the many legal agreements y will encounter during their fessional lifetime.

Designed to take the guesswork of legal paperwork, this valuable f-day workshop focuses on ining contracts and understanding details of contract formation, as ll as covering issues of physician ility, control, duties, npensation, and remedies. Also lressed is antitrust concerns.

n addition, participants will be e to evaluate a contract from an rnative delivery system, and ly skills learned in the workshop analyze the agreement.

The workshop is conducted by ff of the AMA's Department of ctice Management, whose standing teaching style and epth knowledge of medical ctice management has helped ke Practice Management rkshops popular among physicians medical office staff nationwide.

The workshop will be conducted n 8:30 AM to 12:00 PM in anta, GA on January 22, 1988. is $135 for AMA members, and 5 for nonmembers, and includes eshment breaks and workshop erials.

o register, or for more rmation, call the AMA Practice nagement Registrar collect at 2) 645-4958, or write to the erican Medical Association artment of Practice Management, N. Dearborn Street, Chicago, IL 10; Attn: Registrar.

## Nursing Crunch Spawns a Variety of Recruitment Strategies

FACED WITH a nursing shortage that many experts say is here to stay, hospital executives around the country are searching for creative ways to fill nurse vacancies. St. Mary's Hospital of Rochester (MN) implemented an exchange program in January, sending 10 nurses south for the winter, according to Bruce Frederick, assistant administrator for nursing. The program gives St. Mary's sister Mayo Clinic-affiliated facility — St. Luke's Hospital, Jacksonville, FL — extra staff during peak wintertime census periods, and it gives St. Mary's a new nurse-recruitment tool.

But not all nurse recruitment and retention programs are as adventurous as St. Mary's. Day-care centers, exempt job positions, and clinical ''ladder'' programs are becoming more common to keep more experienced nurses by the bedside. Beverly (MA) Hospital and Rush-Presbyterian-St. Luke's Medical Center, Chicago, both operate day-care centers for children of employees.

''As a benefit that not all employers offer, it's a good recruitment and retention tool,'' said Beverly spokeswoman Grace Kushmerek.

In addition to its day-care center, exempt status — making nurses salaried rather than hourly employees — gave nurses at Rush more flexibililty to work around their children's schedules. But Joan Moss, director of the AHA's Division of Nursing, and other hospitals give mixed reports on the effectiveness of exempt status. ''You can promote it as a professional model of practice, but it works best if you have a fairly stable complement of nurses,'' she said. *(AHA NEWS 1987; 23(32).*

## Workshop Helps Physicians Avoid Pitfalls of Joining Group Practice

''PARTNERSHIP AND GROUP PRACTICES: What You Need to Know Before You Sign a Contract'' is a workshop from the AMA that introduces physicians to the personal, professional, and legal concerns that need to be addressed before joining a partnership or group medical practice.

Designed for the resident who is just starting out, as well as the established physician who is interested in joining a partnership or group practice, this valuable half-day workshop addresses issues to help physicians make the right decision before they sign on the dotted line. Topics include group practice opportunities, personal and organizational considerations to think about before joining any partnership or group, valuing a medical practice, contract negotiations, and more. In addition, case studies take the participant through formations of partnerships and groups.

The workshop is conducted by staff of the AMA's Department of Practice Management, whose outstanding teaching style and indepth knowledge of medical practice management has helped make Practice Management workshops popular among physicians and medical office staff nationwide.

The workshop will be conducted from 1:30 PM to 5:30 PM in Atlanta, GA on January 22, 1988. Fee is $115 for AMA members, $135 for nonmembers, and includes refreshment breaks and workshop materials.

To register, or for more information, call the AMA Practice Management Registrar collect at (312) 645-4958.

# *Physician's Recognition Award Recipients*

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from April through June, 1987.*

*The Award was established by the AMA House of Delegates in 1968 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored for Category I credit by organizations accredited for these activities.*

*We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:*

Robert B. Albee, Dunwoody
Manuel L. Alvarez, Savannah
William L. Amos, Columbus
Ivan A. Backerman, East Point
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William N. Handelman, Roswell
John H. Harbour, Smyrna
Frank Hardeman, Savannah
Sanford S. Hartman, Decatur
Charles G. Helmick, Atlanta
Charles A. Henderson, Atlanta
Hugh O. Hodges, Winder
Emory W. Holloway, Macon
Dennis L. Holwerda, Albany
John C. House, Winder
Robert Howard, Macon
Clarence J. Hunter, Statesboro
Henry C. Jackson, Augusta
Floyd James, Dalton
Angelito-Henrito K. Jao, Stone Mountain
Lujean Jennings, Decatur
Bessie C. Jones, Atlanta
Alexander P. Keller, Athens
Henry LaSalle, Covington
John D. Lenton, Tucker
Jeffrey B. Lichtman, Atlanta
Ernesto G. Lopez, Waycross
Marc D. Malkoff, Decatur
Thomas W. Marks, Atlanta
James E. Marlow, Decatur
Duncan R. Marsh, Albany
Virginia V. Martinez, Ft. Benning
Stephen C. May, Kennesaw
William L. McDaniel, Dalton
Albert A. Meyer, Thomasville
Park R. Mitchell, Marietta
Albert J. Mokal, Atlanta
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Virginia G. Mork, Atlanta
Ran Neiger, Savannah
W. Lanier Nicholson, Hiawassee
Benjamin B. Okel, Decatur
Alfonso J. Pardo, Marietta
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Joe M. Phillip, Marietta
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Rogelio C. Poblete, Baxley
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Quentin Price, Dublin
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Otis J. Woodard, Albany
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Howard S. Yager, Atlanta
Mohammad Zafiruddin, Augusta

## OCTOBER

-30 — *Atlanta:* **American College Chest Physicians.** Category 1 edit. Contact ACCP, 911 Busse ighway, Park Ridge, IL 30068. PH: 2/698-2200.

— *Atlanta:* **New Concepts in the anagement of the Diabetic tient.** Category 1 credit. Contact ffice of CME, Emory Univ. Sch. Med., 1440 Clifton Rd., Atlanta 322. PH: 404/727-5695.

-29 — *Savannah:* **MAG Mutual ood Practice Seminars.** Contact anda Duren, MAG Mutual surance Company, 1100 Spring ., Ste. 750, Atlanta 30309. PH: 4/876-8858 or 800/282-4882 (toll e in Georgia).

-30 — *Atlanta:* **Health Care: A sic Human Need.** Category 1 edit. Contact Office of CME, nory Univ. Sch. of Med., 1440 ifton Rd., Atlanta 30322. PH: 404/ 7-5695.

-31 — *Aiken, S.C.:* **Polyps, lyposis, and Colorectal Cancer urse.** Category 1 credit. Contact tty M. Winters, Dir., Jernigan ncer Center, Univ. Hosp., 1350 alton Way, Augusta 30910. PH: 4/826-8900 or WATS: 800/551- 57.

-Nov. 3 — *Atlanta:* **Amer. Coll. /Gyn District IV CME meeting.** tegory 1 credit. Contact ACOG gistrar, 600 Maryland Ave., SW., ite 300 East, Washington, D.C. 024. PH: 800/533-8811 x 341 or 2/638-5577.

## NOVEMBER

— *Unicoi State Park:* **24th nual Psychiatric Institute on Group Behavior and Group Leadership.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5696.

2-6 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6 — *Atlanta:* **Atlanta Area Society for Parenteral and Enteral Nutrition.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

8-13 — *Atlanta:* **American Society of Plastic & Reconstructive Surgeons, Inc.** Category 1 credit. Contact ASPRS, 233 N. Michigan Ave., Ste. 1900, Chicago, IL 60601. PH: 312/850-1818.

12-14 — *Atlanta:* **Georgia Academy of Family Physicians Annual Meeting.** Category 1 and AAFP prescribed credit. Contact GAFP, 3760 LaVista Road, Ste. #100, Tucker 30084. PH: 404/321-7445.

16-20 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/ 727-5695.

18-19 — *Atlanta:* **MAG Mutual Good Practice Seminars.** Category 1 credit. Contact Wanda Duren, MAG Mutual Insurance Company, 1100 Spring St., Ste. 750, Atlanta 30309. PH: 404/876-8858 or 800/ 282-4882 (toll free in Georgia).

19 — *Anaheim, CA:* **Advances in the Diagnosis and Treatment of Cardiovascular Diseases.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/ 727-5695.

20-22 — *Atlanta:* **MAG Annual Scientific Assembly.** Category 1 credit. Contact MAG, 938 Peachtree St., Atlanta 30309. PH: 404/876- 7535 or 1-800-282-0224 (toll free in Georgia.)

## DECEMBER

2-3 — *Atlanta:* **MAG Mutual Good Practice Seminars.** Category 1 credit. Contact Wanda Duren, MAG Mutual Insurance Company, 1100 Spring St., Ste. 750, Atlanta 30309. PH: 404/876-8858 or 800/282-4882 (toll free in Georgia).

3-5 — *Atlanta:* **From Head to Toes Orthopaedics for the Primary Care Physician.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727- 5695.

5-6 — *Atlanta:* **Regional Anesthesia, Surgery, Obstetrics and Pain.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

7-11 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/ 727-5695.

14-15 — *Atlanta:* **Quantitative Thallium Myocardial Tomography.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

# *The Secure Insecurity of Wealth*

THE INSECURITY OF ILLNESS, it seems to me, pales only as it stands alongside the frightening and disarming, at times the near paralyzing fear, that we might someday, somehow, unpredictably, and surely beyond our control come to the day when our money will run out, albeit that we have spent endless hours, days, and perhaps weeks conversing with an array of advisers and counselors in an effort to gain control over and assure the permanent and never-ending security of the fiscal side of our lives. It is a quagmire awaiting us all.

You laugh, "Not me! I went into medicine . . . became a doctor . . . to help suffering humanity!" Perhaps that is true. No, that IS true. No one — no fool, no idiot (Dostoevsky described him) — would do what we do for what we get for it: midnight calls, children growing up without knowing their fathers, or in some cases, mothers (for 30% of our profession is now comprised of women); suicide, divorce, and addiction rates higher than in the general population.

Sam Wilkins, the Winship Clinic surgical oncologist, understood mandatory return for effort expended. He had finished one of those long and trying obliterative surgical undertakings one day and upon talking to the family was asked what his fee would be. Looking at the floor, stooped shoulder from tired muscles, he quietly said, "I just don't know. That operation took so much out of me, I can't put a price on it."

My mother, too, understood money and how to handle it. We were "depression babies," my brother and I. But when it came to her children, mother understood that money, what little there was, represented but a means to an end and not the end itself. We spent a tiny mite on grass seed once to produce a lovely lawn meant for us young boys to roll and play on for which we were reprimanded by our father. "Raise boys or raise grass," she said to him.

There is a balance beam in our lives, and it challenges us to put the control weight where our personal values lie. We must, each of us — we cannot avoid it — ask ourselves the question as to whether or not the practice of medicine is a means to an end or an end in itself. We must, of course, survive in this world that demands of us that we be fiscally responsible and cost effective. Surely we have a justifiable right to expect a fair and reasonable return predicated among other things upon effort, knowledge, and capability. We are not commanded, however, to place financial gain above professional competence and patient compassion. I do believe that the two travel together and are not self exclusive — that the competent and compassionate physician will indeed be the successful physician in all the corridors of his or her life. Show me physicians careful of their professional reputation, jealous of their personal image, and sensitive to the affliction of their patients and I will show you physicians who will be able to live in an air conditioned house, educate their children in private schools, and drive a Mercedes should they so desire.

We deal in this issue of your *Journal* with matters of money, of investing, financial planning, and retirement. Read the articles carefully. The "traps" await us everywhere.

*Charles R. Underwood, M.*

# *AMA To Meet In Atlanta*

THE A.M.A. HOUSE OF DELEGATES is to have its regular "Interim" meeting in Atlanta December 6-9, 1987. This is the first time the A.M.A. has met in Atlanta and provides our colleagues throughout the state an unprecedented opportunity to see the democracy of our policy-making House of Delegates in action. The A.M.A. is different from many of the organizations to which we belong in that policy decisions are determined by a vote of the Delegates as they meet twice a year and debate the issues. These decisions are then implemented by the Board of Trustees.

On Sunday (12/6/87), the House opens with formal speeches, awards, and the adoption of a schedule for the meeting. Reference Committees meet all day Monday to consider *every report* or *resolution* which has been submitted by an individual Delegate, an organization, or the Board. The Reference Committee hears testimony for or against each item of business and subsequently makes a recommendation to the House as to the action it feels is appropriate. This recommendation carries great weight with the Delegates as they consider these reports and resolutions on Tuesday and Wednesday (12/8-9/87).

Each physician attending the Reference Committee meeting, whether a Delegate or not, will be given the opportunity to support or oppose *any* item being considered. It is a unique opportunity to influence the policy of the A.M.A. and is truly a most democratic process.

I would encourage every physician to attend as much of the meeting as possible. For those with an "ax to grind," the Reference Committee on Monday is the ideal forum. For those more interested in debate by the Delegates, then Tuesday or Wednesday will be more appropriate. Regardless of your selection, I can assure each of you that there is an education to be had — as well as an opportunity to influence policy of our profession!

*Harrison L. Rogers, Jr., M.D.*
*Surgeon, Atlanta*
*Past President, A.M.A.*

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*Nancy Psimas, office coordinator, Portsmouth Orthopaedic Associates, Portsmouth, Virginia*

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*Tessa Horne, administrator, Morgantown Ear, Nose & Throat Clinic, Morgantown, West Virginia*

"We love the training program. And the updates they do really help," Ms. Horne said. When a practice brings in over 200 patients a day as this one does, the business office has to run smoothly. "Medic does everything we need. It's great."

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*Jack F. Menendez, M.D.*

## *The Legislative Seminar*

EVERY YEAR MAG hosts a Legislative Seminar. The purpose of the Seminar is to acquaint physicians with the legislative process. It is held during the summer and consists of a "faculty" of capable State Legislators and a "student body" of physicians who attend to learn more about how our Legislature works.

This year's Seminar was at Pine Isle. We were fortunate to have a distinguished faculty of Senators and Representatives and a good turnout of physicians representing almost all specialties. Registration was Friday afternoon. Friday evening we had an introductory dinner with our legislators. The Seminar began Saturday morning with groups of about 30 physicians meeting with a pair of legislators. After some discussion of how a bill becomes law, specific topics such as Tort Reform, AIDS, etc. were discussed. Each physician met with three different pairs of legislators Saturday morning. In the sessions I attended, the discussions were lively. Our physician attendees were well informed and very interested.

Saturday afternoon was given over to recreation — golf, tennis, boating and other events. Saturday evening we all gathered for a pleasant dinner and good fellowship.

Sunday morning we had a special address by Senator Albert Gore, Jr., of Tenn., a candidate for the Democratic Party's Presidential nomination. His remarks were informative and at times humorous. Following Senator Gore's remarks, the Seminar concluded mid-morning Sunday.

Many physicians find the legislative process totally foreign to their training and thought processes. They think, "what has the legislative process got to do with me?" I would answer you thus, gentle reader: 12% of all the bills introduced in the 1987 Georgia General Assembly were health-care related. We *must* become "issue oriented." We *must* be willing to participate in the legislative process. We *must* give of our time and money, for if we don't, we will face changes in our practice that will be intolerable to our patients and to us.

Jack F. Menéndez

## NEW MEMBERS

Burnett, Omer L., Diagnostic Radiology/Nuclear Med. — MAA — (Active N2),
300 Boulevard, N.E., Atlanta 30312

Carter, Frank L., Jr., Diagnostic Radiology/Nuclear Med. — (Intern), Muscogee,
The Medical Center, Columbus 31994

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McLendon, Roger E., Pathology — Tift — (Active N2)
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Nanfro, John J., Hematology/Oncology — Floyd-Polk-Chattoog — (Active N2)
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ein, Bruce, Urology — MAA — (Active N2)
0 Peachtree St. #578-C, Atlanta 30308

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**William J. White,** noted tax attorney, Certified Public Accountant, and former agent, Internal Revenue Service.

**Andrew Morley, M.D.,** Practicing physician, President of Health Services Marketing Ltd., co-author of "Marketing Strategies for Physicians".

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Walker, David M., Family Practice — Stephens-Rabun — (Active)
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Winer, Richard S., Psychiatry — MAA — (Active)
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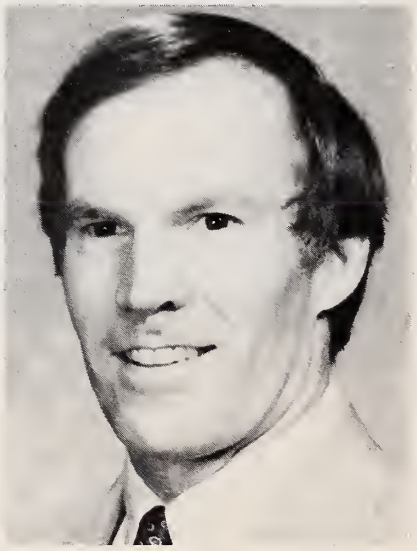
## PERSONALS

**Elizabeth N. Nugent, M.D.,** has been elected president of the American Heart Association, Georgia Affiliate. Dr. Nugent is associate professor of pediatric cardiology at Emory University School of Medicine and a member of the medical staff of Henrietta Egleston Hospital for children in Atlanta. **Richard J. Nijem, M.D.,** cardiologist and chairman of the executive committee of South Georgia Medical Center in Valdosta, is the new president-elect. **John D. Cantwell, M.D.,** of Atlanta, director of preventive medicine and cardiac rehabilitation at Georgia Baptist Medical Center, will serve as medical vice president.

*James A. Kaufmann, M.D.*



*John D. Cantwell, M.D., Atlanta internist, will serve as medical vice-president of the Georgia Affiliate of the American Heart Association.*

**James A. Kaufmann, M.D.,** an internist in Atlanta, has received the prestigious Humanitarian Award of the Atlanta Chapter of the National Association for the Advancement of Colored People (NAACP). The Award recognizes those individuals who have contributed extensively to the betterment of the Atlanta community.

## QUOTES

*When a man is in earnest, and know. what he is about, his work is half done.*
COMTE DE MIRABEAU

*Either I will find a way or I will make one.*
PHILIP SIDNEY

*In everything one must consider the end.*
JEAN DE LA FONTAINE

*New officers of the American Heart Association, Georgia Affiliate, are Atlanta pediatric cardiologist Elizabeth W. Nugent, M.D., president, and Valdosta Cardiologist Richard J. Nijem, M.D., president-elect.*

**Depressed and anxious, she's sitting out life instead of living it**

# From "looking"...

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Please see summary of product information on adjacent page.

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- Rapid results—62% of total four-week improvement within a week versus 44% with amitriptyline[1]
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- Fewer dropouts due to side effects—only ⅓ the rate of those patients taking amitriptyline, although the incidence of side effects is comparable[1]
- Fast improvement with less amitriptyline—⅓ to ½ the dose of patients taking amitriptyline alone[3]

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

**SEE THE DIFFERENCE IN THE FIRST WEEK[1]**

# Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) (IV)

# Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) (IV)

**PROTECT YOUR DECISION. WRITE "DO NOT SUBSTITUTE."**

**References: 1.** Feighner JP, et al: Psychopharmacology 61:217-225, Mar 22, 1979. **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Dixon R, Cohen J: J Clin Psychopharmacol 3:107-109, Apr 1983.

**Limbitrol® (IV)**
**Tranquilizer—Antidepressant**
**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of moderate to severe depression associated with moderate to severe anxiety.

**Contraindications:** Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

**Warnings:** Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

**Precautions:** Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

**Adverse Reactions:** Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

*Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

*Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

*Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

*Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

*Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

*Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

*Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

*Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

*Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

**Overdosage:** Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

**Dosage:** Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

**How Supplied:** *Double strength (DS) Tablets*, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets*, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). Available in bottles of 100 and 500; Tel-E-Dose® packages of 100; *Prescription Paks* of 50.

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# Remembering C. L. Ayers, M.D.

## (1877-1975)

Imagine a Doctor who practiced for 72 years until a few months before his death. Imagine, if you can, a family doctor in the country who delivered more than 5000 babies. Think of going, as he did by horse and buggy, to the homes of expectant mothers and staying there as long as needed until the baby was safely delivered. Think of how it must have been for this doctor during a long, hot summer with load of 20-25 patients with typhoid fever going from house to house by horse and buggy to see these patients. Finally, imagine that this doctor was Secretary of the local County Medical Society for more than 50 years, a record in the State of Georgia and probably anywhere else.

Actually, as you may have guessed, I am not describing an imaginary doctor. I am describing one who was extremely loyal and dedicated to the profession of medicine: Dr. C. L. Ayers.

Dr. Ayers graduated from the old Atlanta Medical College which later became Emory University School of Medicine. He returned to his hometown of Carnesville to practice for a short time before moving to Toccoa, where he remained until his death in 1975.

Among the bits of advice he often gave to us younger physicians was: "Never throw away your old books of account. You never know when you might need one." On one occasion, his habit of keeping everything came in quite handy. There came one day to his office a man needing proof of birth in order to qualify for Social Security. He knew that Dr. Ayers had delivered him, but when he had been born, there was no Courthouse and no vital records. Dr. Ayers dug down in a stack of dusty ledgers in the lower shelf of his bookcase and eventually found the needed record. A Certificate of Birth was written out and given to the man, who then inquired concerning the charge. The doctor said, "Why, nothing for the certificate, but see here, this account has never been paid!" When asked how much it was, Dr. Ayers said "$5.00." So the man paid for his own delivery 65 years earlier to the very same doctor who had attended his birth.

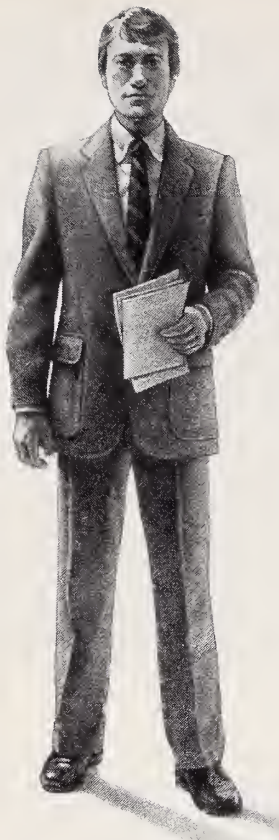
Although Dr. Ayers was not a humorist, he produced a marvelous one-liner one night after the staff meeting at the hospital. Sometime before he and several of his old friends from the Kiwanis Club and their wives had made a grand tour of Europe. France in particular had impressed and pleased him greatly. As he reminisced, he got a dreamy look on his face and said, "I wish I had seen Paris 40 years ago."

"Do you mean when Paris was Paris?," we asked him.

"Nah," he said, "I mean when Ayers was Ayers!"

Some of us older physicians may remember Dr. Ayers. He served his community as a physician and also through many civic offices. He was President of the Ninth District Medical Society and also President of the Medical Association of Georgia. In addition, he served a long term as Chairman of the Toccoa City School Board, and served on the Selective Service Board in World War II. He served two terms as a State Senator. I have often thought that Dr. Ayers' longevity was partially due to the fact that he never hurried and never worried. We would do well to take his example to heart as we spend our personal and professional lives. ■

*(Submitted by Arthur G. Singer, M.D., a radiologist with Toccoa Clinic Medical Associates.)*



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# Health Maintenance For Your Money

David E. Thompson

### Introduction

*"Yes Steve, sounds interesting . . . but at a 28 P-E? Rather rich, isn't it? . . . (Beep) . . . Heck, there's the pager again, gotta go. Oh, 300 shares won't break me. Go ahead and do it. Call me back later."*

As a busy physician, the conduct of your financial affairs is too often interrupted, just like your candlelight anniversary dinner, your child's nursery school graduation, and Super Bowl Sunday. While your wife and 4-year-old love you and will understand these interruptions, your investments are jealous, insensitive, and may severely punish you for any inattention or error in judgment.

Also, physicians are constantly solicited by various financial representatives offering investment products which, at first glance, appear to have some merit. However, investments, like medicine, must be prescribed as part of a well coordinated program which considers the "patient's" investment objectives, financial constraint profile, and how different investments (like medicines) might interact.

This article will briefly discuss:

1. An overview of risk and return.
2. How to set your investment objectives.
3. Securities for the long-term portfolio.
4. How to find sensible, comprehensive investment advice.

### Risk And Return

Understanding the basic relationship between risk and reward is a fundamental prerequisite for successful investing or even setting your investment objectives.

The phrase, "no risk, no reward" may be an oversimplification, but it provides a good starting point. All investments offer a potential level of reward as compensation for a particular level of risk; generally, the lower the level of risk, the lower the potential reward.

Investments contain two types of risk: market value risk and purchasing power (inflationary) risk. Market risk can be further divided into systematic or unsystematic risk. Systematic risk is the risk inherent in a particular type of security and cannot be diversified away. For instance, if interest rates rise, bond investments will lose value whether they are low-rated "junk" bonds, AAA rated corporate bonds, or even federal or federal agency bonds. Unsystematic risk is the risk that the price of your bond will decline more than bonds in general. This risk can be reduced by improving diversification or investment quality.[1]

Investments should normally be evaluated on a total return basis, that is, the projected return on investment from both current income and potential capital appreciation. Nevertheless, based on their desired preference in total return, investors usually classify an investment as an income or growth vehicle, depending on its current income yield. Normally, the higher the current yield, the lower the potential growth. If the potential growth is below average, a high current yield becomes the alternative investment inducement.

### Securities For The Long-Term Portfolio

Most investment professionals would agree that investing in a complement of fixed income and equity investments provides an excellent opportunity for long-term growth of asset value and income.

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The most popular fixed income investments include money market instruments (such as Treasury bills, short-term bank certificates, and corporate commercial paper), bonds, notes, and mortgages. The primary equity investments are common stocks and real estate.

Common stocks remain the most popular long-term investment vehicle due to their marketability, dividend income, as well as the numerous sources of information about them. Above all, despite market volatility over the years, common stocks have appreciated more than other liquid securities (Figure 1).[2]

The allocation between various fixed income and equity investments should be based on the investor objectives and constraints discussed below as well as an analysis of current and expected financial market conditions, a complicated topic which is a subject unto itself.

### Investor Objectives and Constraints

Before consulting an investment professional or implementing your own investment program, you should consider your current investment objectives and financial constraints as you see them. Identifying both your objectives and constraints simultaneously is crucial, for this should reveal short and intermediate term "implied objectives" to attain enroute to your long-term investment objective. For instance, achieving a long-term objective such as accumulating $x for retirement at age 60 necessitates achieving interim objectives such as retiring $y of debt from medical school, practice start-up costs, and children's educational expenses.

Individuals often express their investment objectives in terms of how they view themselves as investors, such as conservative, moderate, or speculative. However, wherever possible, the investment objective should be spelled out as a dollar amount to be accumulated within a given time period, a level of income to be maintained, or some combination of the two. The conservative, moderate, or speculative labels relate more to one's portfolio orientation or, more precisely, the particular risk-reward posture taken. Young adults normally have long careers ahead of them with the potential for substantial income growth; they should have the longevity to assume greater risk. As time progresses, the need for current income increases; this usually prompts a reduction in one's overall portfolio risk orientation.

***Investments should normally be evaluated on a total return basis, that is, the projected return on investment from both current income and potential capital appreciation.***

Nevertheless, this "life cycle" to risk relationship is not inflexible. Just as some 70-year-olds run marathons, some of their portfolios do also, adopting a higher risk-reward posture than expected. First you, and then you and your financial advisor, should consider the following constraints as you determine the correct risk-reward posture:[3]

1. Current Income Requirement — which prompts these questions:

(a) How much income should my portfolio generate?

$$\text{Minimum Portfolio Income Requirement} = \text{Your Annual Income Need} - \text{Investment Income}$$

(b) What current income rate (or yield) should my portfolio earn?

$$\text{Minimum Portfolio Yield} = \frac{\text{Minimum Portfolio Income Requirement}}{\text{Size of Portfolio}}$$

(c) How much extra inflation protection do I need? This is important if your portfolio will provide funds for a second home, college tuition, or other escalating costs.

2. Liquidity Requirement — how much and how soon will the next withdrawal of funds be?

3. Market Value Risk Tolerance — prompts these questions:

(a) How much can I afford to lose? Theoretically, this is the amount that can be invested in stock or other higher risk ventures.

$$\text{Potential Equity Position} = \text{Portfolio Value} - \text{Expected Near Term Obligations}$$

(b) How much sleep will I lose while the money's at risk? Be honest, it may be more than you think.

4. Your Life Cycle Position — as discussed earlier.

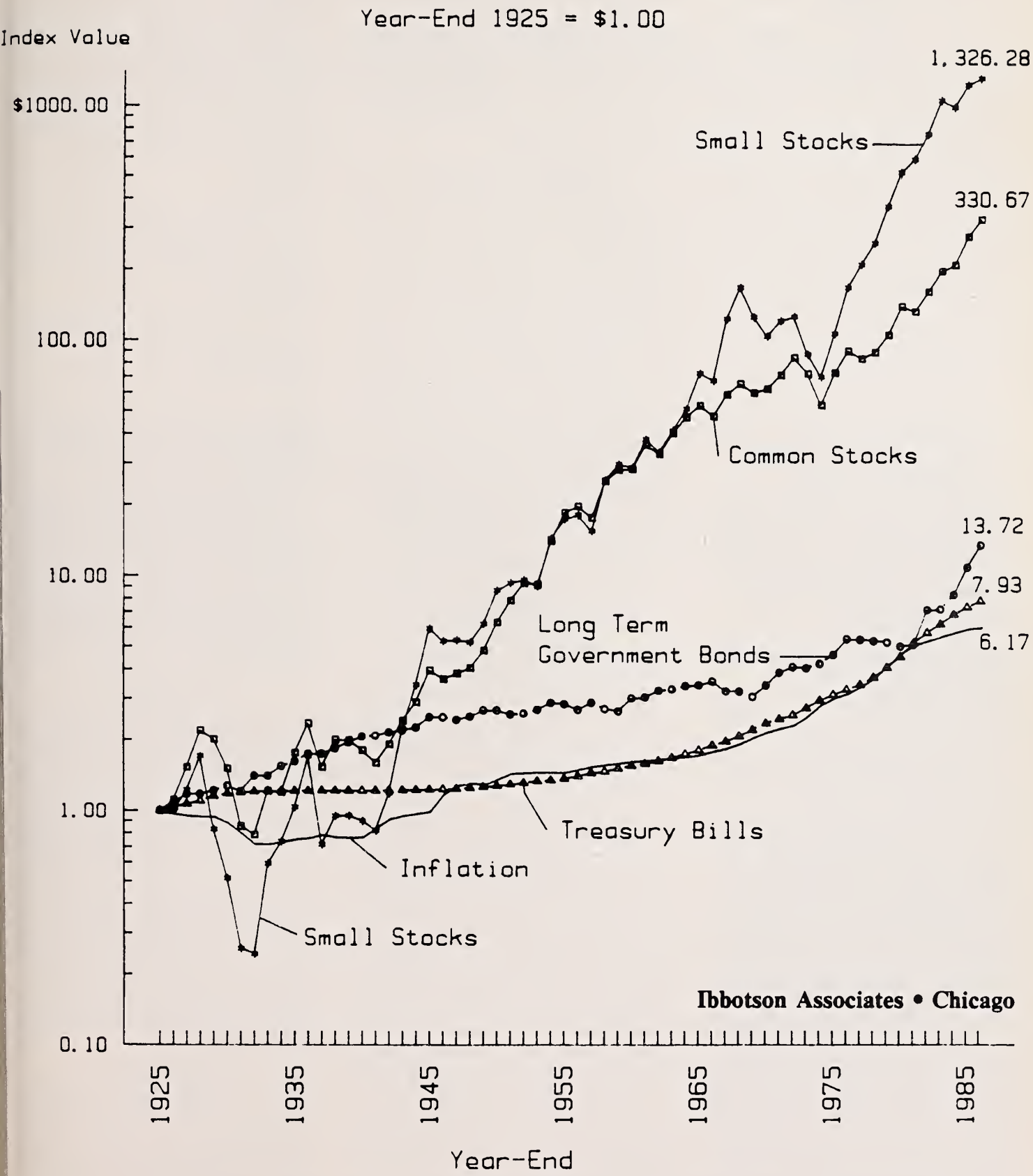
5. Tax Considerations — are important in order to maximize after-tax returns. Municipal bonds are one of the few tax advantaged vehicles remaining after the recently enacted, so-called tax simplification legislation. To compare the advantage of a tax-free versus taxable investment, calculate the equivalent taxable yield of the tax-free vehicle using the formula below. If this yield is higher than the alternative taxable yield, the municipal might provide a higher net return. Nevertheless, before considering any tax advantaged investment, you should consult your accountant or tax attorney. Furthermore, when considering other tax advantaged investments such as tax shelters (what few remain), don't let the tax savings be the only compensation for an otherwise marginal or poor investment.

$$\text{Taxable Equivalent Yield of a Municipal Bond} = \frac{\text{Tax Exempt Yield (Decimal)}}{(1 - \text{Your Tax Bracket (Decimal)})}$$

6. Legal Constraints, Other Unique Needs — do you have estate planning considerations or just want your money manager held to a higher than usual standard of

Figure 1

# WEALTH INDICES OF INVESMENTS IN THE U.S. CAPITAL MARKETS



competence? If so, you might want to consider a fiduciary account such as a trust.

### Finding Prudent Investment Advice

Do you really need outside investment advice? The answer is an emphatic YES. Just as your patients surely need you for professional health maintenance or periodic treatment, your investments also need professional care. Regardless of your investment savvy, the truth is most practitioners simply do not have the time to manage their own investments. (If you don't believe me, ask your wife and child.) By all means, if investing is your hobby, set aside some funds and "go for it", but seek professional care for your primary long-term portfolio.

***Like the medical professional, the investment professional should subscribe to and enforce compliance with a set of professional standards of conduct.***

How do you find prudent investment advice? Ask another professional who is likely to work with investment professionals. Your banker, accountant, or attorney would seem good sources. Your colleagues can also give you leads.

Who provides the advice? The best known are bank trust and investment management departments, investment counseling firms, and investment brokerage firms.

1. Bank trust and investment management departments, contrary to popular knowledge, manage portfolios with a wide range of risk-reward postures, ranging from ultra conservative to highly aggressive. Many are established, objective, and successful money managers with favorable track records. They do a lot more than just manage trusts, estates, and other court-supervised fiduciary accounts. Furthermore, even the fiduciary accounts have a wide range of risk-reward postures. Compensation is based on investment performance — account size and income generated. Most trust departments utilize both in-house and outside investment research.

2. Investment counseling firms also manage a wide variety of accounts, but most of their personal accounts are non-fiduciary investment advisory accounts. However, under the guidelines of ERISA, they often act as fiduciaries for employee benefit accounts. Like bank trust departments, investment counseling firms are compensated on a percentage of assets managed.

3. Investment brokerage firms remain the best known investment concerns which offer a broad array of investment products and maintain large research staffs. Their individual account executives do not normally manage fiduciary accounts and are compensated on a sales commission basis.

Here are some factors to consider in picking an investment advisor:

1. The advisor, bank or otherwise, should have a growing base of assets under management. This should indicate steady investment performance and a steady or growing customer base.

2. An individual's actual years of investment experience or the average investment experience within an organization is very important. Also consider relevant education such as an MBA or certifications such as the Chartered Financial Analyst or Certified Financial Planner designations or the New York Stock Exchange Series 7 Licensing Program. Nevertheless, nothing beats experience acquired during both rising and falling markets.

3. Accordingly, for your long-term investment program, the goal of the advisor should be to provide consistently superior investment performance over successive 3 to 5 year periods. Some managers will strongly outperform the financial markets for a year or two, only to underperform them subsequently. Consistency is the key.

4. To provide consistently superior results, the manager should have clear policies regarding both fixed income and equity investment management. The advisor should be able to clearly discuss policies regarding:

(a) Security selection, retention, and, above all, SALE;

(b) Dissemination of policy and strategy decisions throughout the organization;

(c) Formal and informal account review and customer contact procedures; and

(d) Supervision of policy adherence.

Strategies and policies should be clearly defined, disseminated, and followed.

5. Like the medical professional, the investment professional should subscribe to and enforce compliance with a set of professional standards of conduct. The standards established by The Institute of Chartered Financial Analyst are a good example.

### Conclusion

As a physician, your schedule is extremely demanding — often brutal. Many projects can be conveniently rescheduled. Your investments are NOT one of them. Take the time to assess your own career path as well as your investment objectives and constraints. Then find an investment professional who will work with you and, as required, your attorney or accountant, to develop, implement, monitor, and adjust the right long-term investment for you. Otherwise, the beeper will be left in charge. ■

### Reference


1. Maginn and Tuttle, *Managing Investment Portfolios: A Dynamic Process* (Boston, 1983), pp. 11-12.
2. Ibbotson Associates. Stocks, Bonds, Bills, and Inflation 1987 Yearbook (Chicago, 1987), p. 9.
3. Maginn and Tuttle, pp. 131-135.

# FINANCIAL PLANNING:
## Are You Getting The Real Thing?

Gregg W. Schuder

"SUCCESS IS SIMPLY a matter of luck. Ask any failure." The irony in this wry observation is that all too many people conduct their financial affairs as though they, in fact, are willing to rely on luck. Others, unfortunately, think they have a sound financial plan, only to learn in some extremity that their plan is neither comprehensive nor objective — two essential characteristics of the real thing.

As a medical professional, you probably have been approached about financial planning in the past but may still be confused about the process. In this case, you may find it helpful to take a quick look at ten of the elements which should be included in every financial plan.

*1. The Plan Should Include a Precisely Worded Section on Your Goals and Objectives*

This is the most critical component of a financial plan. Every element in the plan derives its existence from your goals and objectives. To be worthwhile, a plan must be designed for you and no one else. The goals must be your goals, not the planner's or the "average" person's. This section should state exactly what you want to accomplish. The concepts should sound familiar to you and "feel right." They should define exactly what you discussed with the planner during the initial interviews. Because this section is so important, make sure you communicate clearly with your planner.

*2. The Plan Should Evaluate All the Major Financial Areas*

To be comprehensive, a financial plan must be based on all the major financial areas and their application to you. A plan should address your needs relative to: 1) a cash reserve, 2) investments, 3) taxation, 4) insurance, 5) retirement, and 6) estate planning.

Mere inclusion of these areas is not enough. The plan should be thorough within each of them. In the insurance area, for example, beware if all that is discussed is life insurance. The possible need for disability income insurance should always be addressed as should the level of your malpractice insurance. Homeowner's, auto, and personal umbrella liability coverages should also be discussed.

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*3. The Plan Should Measure All of Your Assets*

A financial plan measures your progress toward goals by first taking inventory of what you have — where you are now financially. Omitting some of your assets, for example your professional corporation, from the inventory will throw this measurement off and indicate greater needs than you actually have. In many cases, a person's greatest asset is his earning power. For this reason, discretionary income should be used in charting progress towards goals.

*4. The Plan Should Be Understandable*

A financial plan is not much good to you if you don't know what it says. This is your document, and you should be able to make sense of it. Inevitably, it will be involved, but it should be readable. Good plans often have executive summaries in the front, with recommendations highlighted. Remember that your in-depth participation is the key to the formulation of a viable plan and to your understanding of that plan. A Chinese proverb sums it up: "I hear and I forget. I

see and I remember. I do and I understand."

*5. The Plan Should Make Specific Recommendations*

A specific remedy should be recommended for each problem area the plan discovers. You will decide whether to take this specific advice, but your plan should select and justify an option for you. There are a few exceptions to this rule. The most notable is found in the estate planning area. Only an attorney should make specific recommendations concerning a will and estate plan. Your planner, however, may enlighten you in this area and discuss some of the options open to you.

*6. The Plan Should Address Your Investment Risk Tolerance*

Every plan should take into consideration the degree to which you feel comfortable taking risks with your investment dollars. Your planner must understand how you feel about taking risks, and your plan should reflect this understanding. The literature that accompanies any investment recommended by the planner should allude to risk and the risk should be consistent with your tolerance.

*7. The Plan Should Justify Any Life Insurance Coverage Recommended*

If you need life insurance, your plan should explain why and pinpoint the amount of your current, as well as expected future, needs. The important thing to recognize here is that the amount of insurance recommended is not magically derived. It is the sum of parts that are understandable and should be so presented to you in your plan.

*8. The Plan Should Compute Your Expected Retirement Income*

It has been our experience that most people who set financial goals select financial independence as their top priority. They want to be able to retire at a specific age should they so choose. If you desire to ensure financial independence at a given point in your life, your plan should tell you what you can count on in the way of income from existing assets and savings plans, maintained both personally and by your professional corporation. This estimate should incorporate the growth and inflation rates you and your planner have discussed.

*9. The Financial Plan Should Address Your Will and Estate Plan*

No financial plan is complete without addressing your will and estate plan. If your net worth is in excess of a million dollars and increasing, your plan should go into detail, explaining some of your estate planning alternatives. This size estate needs strategies for reducing the ultimate estate tax liability.

Even in the case of a smaller estate, your will should be considered and an estimate made of the value of your estate. The plan should at least advise you that the major dispositive provisions of your will accurately reflect your intent. Again, your planner cannot give you a legal opinion on the soundness of your will or estate plan.

*10. The Plan Should Address Tax Savings*

Even given lower federal tax rates, your tax liability can still be substantial. For this reason, taxes will continue to affect most financial planning decisions, and your plan should, of course, recognize this. With the frequency of tax changes that have been instituted in the last few years, it is questionable whether you can accurately project and plan for taxes over a 3 to 5 year horizon. Nonetheless, projections given current law should be made, and the sensitivity of your plan to tax changes should be addressed, so that you are better prepared to respond to change.

***

Keeping these 10 guidelines in mind will substantially improve the odds that you will have a comprehensive and objective financial plan — the real thing. ■


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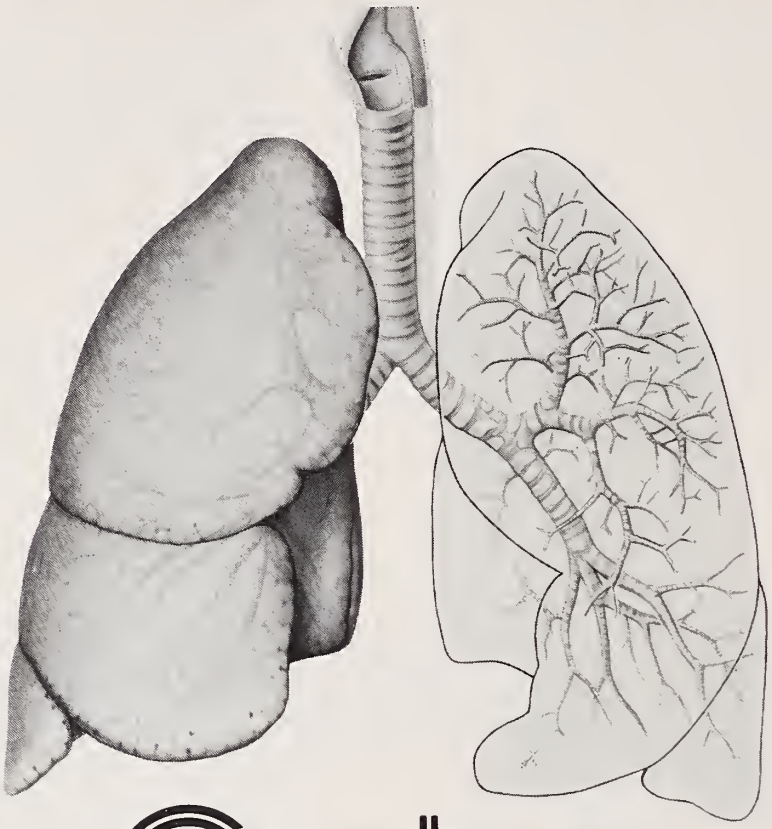

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## offers effectiveness against the major causes of bacterial bronchitis

*Haemophilus influenzae, Streptococcus pneumoniae*
(ampicillin-susceptible and ampicillin-resistant)

*Note:* Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

**Summary. Consult the package literature for prescribing information.**

**Indications:** Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A $\beta$-hemolytic streptococci).

**Contraindication:**
Known allergy to cephalosporins.

**Warnings:**
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

**Precautions:**
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

**Adverse Reactions:** (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea), 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever), 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

**Abnormalities in laboratory results of uncertain etiology**
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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# The Practical Matters of Practicing Medicine

Joyce Divinyi

***There are a growing range of business management alternatives available to doctors that also save time and money, but are less frequently used.***

IT IS NOT NEWS that few physicians enjoy dealing with the complex business issues involved in the management of a successful medical practice. Because doctors are so often uncomfortable in dealing with business issues, they frequently overlook the many resources available to assist them in the area of medical practice management.

Physicians, naturally enough, want to heal the sick. They spend years in training and preparation for that mission. In most cases, they spend *no* time in training and preparation for the task of operating a business. And of course, establishing, developing, and managing a successful medical practice requires competent business skills as much as it does expert medical skills. In fact, the practice of medicine has become more and more dependent on effective and efficient business practices.

Due to a number of factors beyond their control, physicians are being challenged to become skilled businessmen and to take a more active role in the day-to-day management of their practices. Income increases for physicians are at a standstill while business costs are rising. The enormously increasing cost of liability insurance, a decline in the number of patient visits per doctor per week, combined with an increase in the number of physicians practicing,[1] are creating new pressures for physicians in every medical practice situation.

New insurance plans are forcing many doctors to accept lower fees or lose patients to doctors joining the plans. The new plans are also generating increased paper work for doctors and their staff.[2] Clearly, the ratio of fee increases to business cost increases is uneven.[3]

Physicians are handling the new business pressures in a variety of ways. Some have hired business managers to run their practices. Some rely on their spouses to attend to their practice management concerns.

These methods of dealing with increased business pressures can be, and often are, beneficial. There are, however, a growing range of business management alternatives available to doctors that also save time and money, but are less frequently used. Physicians are accustomed to seeking expert and specialized assistance to treat complex medical problems. Seeking expert and specialized assistance to solve complex business problems can be equally advantageous.

Growing in favor with many doctors are a variety of computerized medical management systems. These systems are specifically designed for physicians in both solo and group practice. The systems facilitate insurance claims filing, pa-

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tient billing, collections, and office accounting. They can be individually designed to meet the special needs of each practice; most of all, they can significantly decrease the possibility of employee embezzlement.

Accredited continuing education is available through many local hospitals to train office staff on the efficient operation of medical practice computer systems. Companies selling and installing systems train staff in the use of the system, but staying abreast of the intricacies of insurance claims filing has become increasingly more complex as cost containment pressures increase. Companies specializing in medical staff training programs make it possible for physician's staff to stay current on insurance claims coding and filing.

Other types of office staff training programs are available to enhance the efficiency of medical practice management. They include a wide range of office management programs as well as patient relations and medical practice marketing seminars. Some are available on video tape, making it possible for doctors and their staff to enhance their business management skills in the comfort of their home or office.

While the relatively new concept of medical practice marketing creates ethical conflicts for some physicians, it is an area of business management that should not be overlooked. Often, medical practice marketing is perceived as synonymous with advertising. In actuality, medical practice marketing encompasses a range of services, including patient education and practice specialty brochure development, referral building and referral follow-up systems, development of office policy and procedure standards and manuals, staff communications consultation to help identify and correct practice management problems, staff/patient contact training, practice newsletter publication and public relations services (press releases, special events planning, public speaking arrangements). Physicians entering solo practice or groups expanding with the additions of new doctors can benefit from these services.

To meet the growing business management needs of physicians, some large accounting firms are offering a full range of practice management and marketing services. Long-established medical practice management firms are now providing physician marketing services.

Other companies previously providing products and services to physicians are also expanding. It is now possible to purchase both office and medical supplies through one central supply company. Office managers can order paper clips, typewriter ribbons, and a complete range of medical supplies from the same supplier. A single billing at competitive prices for both office and medical supplies can save time and money.

Yet, with so wide a variety of business management assistance available to physicians, it is still common to find doctors overburdened with management concerns and frantically trying to find time in an already unmanageable schedule to do everything themselves. Often they are concerned that a new service will be just another financial drain without any added benefit. Sometimes strong negative concepts regarding business management services, such as marketing, prevent doctors from retaining the professional expertise they need. Some doctors are unaware of management problems within their own practices, and frequently office managers or supervisors are reluctant to point out areas of concern or suggest new ideas. Most of all, it can take time ot locate the right assistance.

Still, the above mentioned services will almost assuredly result in time gained and money saved in the long run. Personal testimonials remain the most effective method of determining the value of a new service if physicians will develop the habit of talking to one another about practice management concerns. It is time for doctors to take advantage of the resources available to them and to assist one another as businessmen as well as physicians.

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# The Medical Professional As An Individual Investor: Often Misunderstood and Forgotten

Brion D. Friedman

As a medical professional, you obviously recognize the necessity for looking at your patient in his entirety — not simply as a housing for a heart or a respiratory system or a set of veins and arteries. Additionally, you want to observe and learn what you can about his emotional health, for example, since this could be a critical factor in the effectiveness of any treatment you may administer.

So it should be with any investment adviser that you, the medical professional, might select for the care and maintenance of your personal financial health. Your investment adviser should learn a great deal more about you than just the amount of money you plan to invest. He should remain constantly aware that you have needs peculiar to your profession, circumstances, and psyche.

As is the case with any individual investor in today's society, the medical professional is a unique and important player in the world of investments. However, his goals and strategies are often misunderstood both by him and by those who advise him. Generally being much smaller, but often much more complex, than the institutional investor, the individual investor is finding making investment decisions more and more difficult as his options continue to increase.

With vehicles ranging from treasury bills to commodity futures to research and development limited partnerships, the individual investor is often faced with spending a disproportionate amount of time and effort within his busy schedule in order to achieve superior returns from his portfolio.

### Make-up of the Medical Professional as an Individual Investor

Because each person is unique, it follows that his investment strategy should be, too. To be sure, he may own the same stocks as his neighbor, but his motivation for investing, his tolerance for risk, and his expectations for performance are almost certain to be different.

Two important facets in looking at any individual investor should be considered: psychologic aspects and risk tolerances. Each person has certain physical, emotional, and intellectual needs which drive his actions. Some people are motivated primarily by the very basic need to survive; some, by a need to gain acceptance from others, and some, by a self-actualizing desire to improve themselves. These and other motivating factors must be considered in the investment process. In fact, identifying a person's needs builds the necessary foundation from which an investment strategy can start.

An individual's biases, developed for whatever reasons, must also be taken into consideration in looking at his psychologic make-up. These will affect the selection of investment vehicles on the most fundamental level. For instance, if one dislikes stocks because he has had significant losses in the past, this feeling will pervade his investment strategy. It is imperative that

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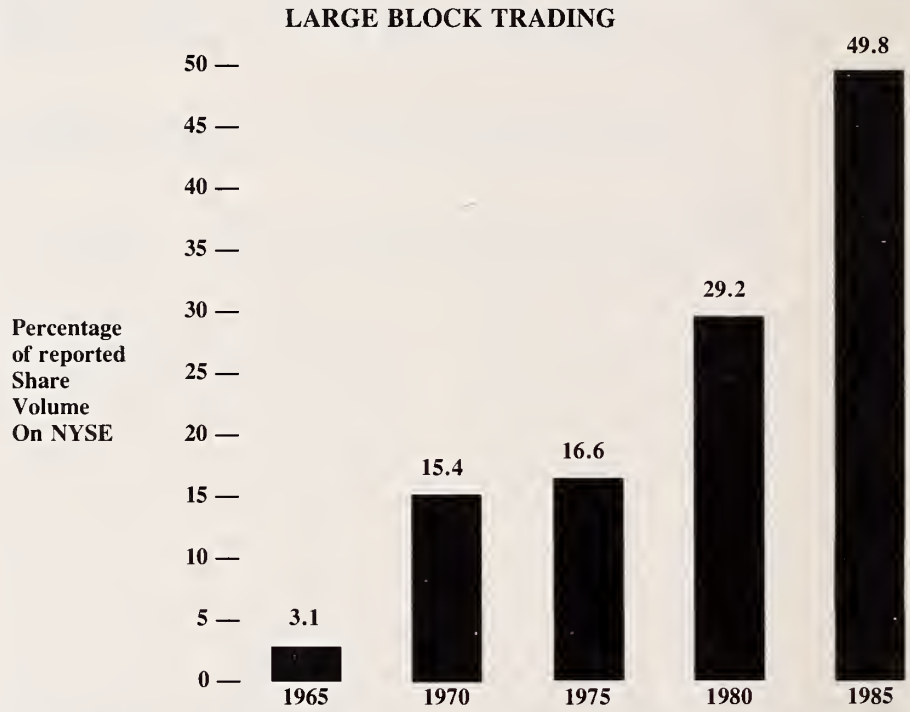
such biases be identified and assessed as to their validity within a prudent investment portfolio. After all, the investor must feel comfortable with his investment.

Most people are risk averse. That is, they would rather have a sure $250 gain than a 25% chance at a $1,000 gain. The degree of risk tolerance varies from individual to individual and has a marked effect on investment portfolios. Of course, almost every investor must deal with one or more of several types of risks — interest rate movements, liquidity/marketability, changing tax laws, time horizons, and default or credit risk, to name just a few.

What's more, people are loss averse. In medical terms, "losing" is simply not in the vocabulary of those involved with patient care. Loss avoidance is a key consideration in determining an investment strategy, and, again, the intensity of this feeling varies from person to person. Psychologically, a loss makes more impact on a person than does a gain of equal value. Therefore, a realistic appraisal of an individual's ability to deal with losses is also necessary in the investment process.



The increase in large block trading (trading of 10,000 shares or more) since 1965 shows the rapidly growing influence of institutions in today's stock market.

### The Individual vs. the Institution

Institutions have played an increasingly larger role in investment markets over the past 20 years. One need only look at the growth in "block trading" — a measure of institutional activity represented by trades in excess of 10,000 shares — to see the dramatic increase in their activity.

In 1965, block trades (Figure 1) were only 3.1 percent of reported share volume on the New York Stock Exchange. By 1985, they accounted for 49.8 percent of exchange activity. By comparison, the actions of individuals seem almost insignificant. In fact, the activity of the individual investor is considered an inverse indicator of market movements. All too often, when individuals react to trends in the markets, the trends are about to reverse.

This growing feeling that the individual cannot compete effectively with institutions in the market has helped lead to the growth in mutual funds in recent years. Through the use of these funds, the individual has been able to "institutionalize" himself. Nevertheless, in comparison to the institution, the individual seems to be a much more complex investor. He is allowed to select from all the possible investment vehicles as opposed to institutions, which are often limited in their investment possibilities. Thus, the allocation process is much harder for the individual.

Also, the institutional investor for the most part has an infinite time horizon and deals with very little internal change. On the other hand, the individual has a limited life span and his situation changes constantly, as he grows older. Additionally, the complexity of the individual investor vs. the institution

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can be seen in the individual's greater need to pay attention to tax consequences.

Time for analysis of investment opportunities is yet another factor that separates the individual from the institution. The institutional investor has a staff of people whose responsibility is to find good investments. The individual, however, spends the majority of his time working on his business or job. Little time is left to deal with important personal investment decisions. Therefore, he must either let his personal investments suffer due to lack of attention or find someone to manage them.

### The Individual: Who Needs Him?

The growing size of the institutional investors, such as pension funds and profit-sharing plans, and their relative simplicity, as compared to individual investors, explains why so many investment managers and advisers have gone after the institutional investment accounts. Behind, they have left the individual who needs more help now than ever in making investment decisions.

### Where Should the Individual Investor Look for Help?

You, the medical profession should seek guidance from an investment adviser who, from the beginning, understands, among other factors, your needs and risk tolerance and who, through proper monitoring, adapts to your changing personal circumstances. An individual investor can expect to pay for investment advisory services based on the dollar value of his assets under management. As an example, fees for the first $1 million may range from 1 percent to 2 percent with the percentage declining for amounts in excess of the base investment. ■


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# Retirement: Is It For You?

John M. Hodges, M.D.

***Retirement can be a rewarding, successful time of life if you accept the inevitable changes and remain active and involved in a variety of activities.***

Retirement . . . people's thoughts about it vary considerably — from exhilaration, excitement, and pleasant anticipation to dread, repulsion, and avoidance. Where are your thoughts in this spectrum? Let us look at some of the most important factors influencing our attitude about retirement.

**Age:** It is often difficult for people to accept that their capabilities and responses are not as sharp as they once were. It is even more difficult for people to admit that they are performing unsatisfactorily because of the physical and mental deterioration that often accompany their advancing age. For the sake of uniformity, it is desirable to set a retirement age for corporation employees, professional people who use their muscle and brain power for fine movements and decisions, and people in a responsible capacity over other people's funds and lives. In my opinion, these three classes of workers should step down and make room for younger people whose reflexes and muscle coordination as well as mental capacity are better.

Chronologic age is not an absolute indicator of the time one should stop his or her work and head in a different direction, however. Some people aged 55 to 60 are in much poorer physical and mental health than people 70 to 75 years of age. Although the retirement age was arbitrarily set at 65 many years ago, there has been much consideration recently about raising it to 70.

**Activities:** Retirement need not be the "end of your world," nor a time of becoming sedentary and useless. Many people are busier after retirement than they were before because they enjoy being active, useful, and involved. There are books to read, courses to study, sports in which to participate, cards to play with friends, charity and church work to do, and even a game of solitaire can be fun. Decisions about such activities should be made *before*, not after, retirement.

One's attitude will govern to a great extent the quality of one's retirement. A person ideally should put in the background their past schedule and daily life and learn to accept that their retired life will be different. Which brings to mind what Abe Lincoln once said, that "People are about as happy as they make up their minds to be."

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**The Spouse's Adjustment:** Another member of the family who must also accept the changes inherent in retirement is the spouse. In the case of a wife, for years perhaps she has managed the home while her husband was busy with his business or profession. She now faces the prospect of finding him home "under foot," and perhaps making decisions that for years have been her responsibility. How is she going to react to this? This must be thought about and discussed openly by both partners before retirement to ease the period of transition. There are bound to be problems that can be ameliorated and/or solved by effective communication between spouses.

**Money Matters:** One question which inevitably arises is, "Can I afford to retire?" This depends on your lifestyle. If you own a home which is free of any debt and are content with it, if you do not want to rent or purchase an expensive condominium or vacation home to use part of each year, if you are satisfied with one or two medium-priced cars rather than the expensive status ones, if you do not want to take expensive cruises or round the world trips every few years, if your hobbies are reasonable ones, not diamond or expensive art collecting, then I would think an annual income of $50,000 would be adequate. Your financial planner, however, can better advise you than I. In my opinion, one should not retire if their annual income is less than $50,000. Many otherwise happy retirements are managed on an income of much less, but a strain is put on the marriage relationship if there is not enough money available to live in the style to which you are accustomed or happy. No one knows what it is going to cost to live in the future. In these days of fluctuating inflation and new tax changes, my figure of $50,000 may be far too little, but it is my baseline for the present time.

In summary, retirement can be a successful, rewarding time of life if you and your family accept the inevitable changes, if there is enough money for you to comfortably live as you desire, if you are willing to find things to do rather than grumble about having nothing to do, and if you do not dwell on your past life but enjoy the present moments as they occur. ■


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to find
just the
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## Surprising? Not really.

Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.
A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients[2] revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol — which shows how well-tolerated once-daily INDERAL LA can be.

## Sole therapy or concomitant therapy? Fifty-nine percent of the time, INDERAL LA stood on its own.

The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were treated merely with the addition of a diuretic to INDERAL LA.

## For the noncompliant patients in your practice, INDERAL LA may well be the answer.

Almost 20,000 of the patients in the nationwide compliance trial were identified as having been noncompliant with their previous antihypertensive therapy. Their physicians reported that 88% showed improved compliance when placed on once-daily INDERAL LA.

# Control, comfort, and compliance

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Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

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Please see next page for brief summary of prescribing information

# The one you know best keeps looking better

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

**INDERAL® LA** brand of propranolol hydrochloride **(Long Acting Capsules)**

**DESCRIPTION.** INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

**CLINICAL PHARMACOLOGY.** INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

**INDICATIONS AND USAGE. Hypertension:** INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

**Angina Pectoris Due to Coronary Atherosclerosis:** INDERAL LA is indicated for the long-term management of patients with angina pectoris.

**Migraine:** INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

**Hypertrophic Subaortic Stenosis:** INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

**CONTRAINDICATIONS.** INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

**WARNINGS.** CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

**Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)**—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing $T_4$ and reverse $T_3$, and decreasing $T_3$.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

**PRECAUTIONS.** GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

*Aluminum hydroxide gel* greatly reduces intestinal absorption of propranolol.

*Ethanol* slows the rate of absorption of propranolol.

*Phenytoin, phenobarbitone,* and *rifampin* accelerate propranolol clearance.

*Chlorpromazine,* when used concomitantly with propranolol, results in increased plasma levels of both drugs.

*Antipyrine* and *lidocaine* have reduced clearance when used concomitantly with propranolol.

*Thyroxine* may result in a lower than expected $T_3$ concentration when used concomitantly with propranolol.

*Cimetidine* decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

*Theophylline* clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS.** Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

*Cardiovascular:* Bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

*Central Nervous System:* Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy and vivid dreams appear dose related.

*Gastrointestinal:* Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

*Allergic:* Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

*Respiratory:* Bronchospasm.

*Hematologic:* Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

*Auto-Immune:* In extremely rare instances, systemic lupus erythematosus has been reported.

*Miscellaneous:* Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

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# THE WAY IT IS

Ward Pafford, Ph.D.

***I was at last at liberty to pursue, if you will, the life of the mind without fretting necessarily about adapting my explorations and reflections to the dictates or whims of others.***

ALMOST EVERY ONE with sound natural equipment and prospects looks forward to (or, perforce, must face) withdrawal from the more-or-less normal experience of full-time vocational entrapment. The old adage, however, that every case is different must hold true here. Moreover, as our average life-span lengthens, as the maturer segment of the population expands, and as geriatric specialties and specialists multiply, individual differences become even more pronounced. Hence there is some justification (or ought to be) for an informal first-person account of a single individual's reactions to retirement as distinct from loftier professional conclusions and generalizations. Sociology is one thing. The truth in the individual case is another.

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I have been a retired educator for nearly a full decade, having let the reins go as a retired professor of English with collateral experience as a college department head, academic dean, and president. I was for almost 50 years mainly a teacher-student, a modestly productive scholar, and by no means a professional management person. I suppose I derived most satisfaction from the study of great literature and from my association, personal and professional, with students and colleagues. In between, in odd moments and moods, I cultivated all along the habit of jotting down words, phrases, lines with private creative purposes in mind. I have never been able for very long to resist the deep inner urge to get back to the writing table. Little of this mostly covert pursuit has ever amounted to anything of special note, but I am certain that my friendship with language and the stuff of the imagination has helped greatly in holding onto a semblance of balance and sanity.

It has always seemed clear to me that I had definitely superior advantages in preparing for retirement, should I survive long enough. The college and university campus is hardly any more the quiet retreat of legend. But for most of my time as a member of the academic community, I felt that it served me as a sort of shelter, a relatively out-of-the-way and protected refuge where serious thought and study of an honestly disinterested kind and devoted to subjects of profound importance to human beings continued to be encouraged as useful preoccupations. We

worked hard late and soon. Our work may not have been immediately and directly tied in with the acquisitive concerns of life beyond the campus, but I had the conviction that what we were doing was of the greatest significance in a civilizing process indispensable to human society. In sum, I spent most of my employed years actually in a situation of pretirement so that I could do the work demanded by my profession.

***I have found contentment in and realized solid profit from other activities and preoccupations — and I have learned long since to live fairly comfortably with my excuses for not driving hard to get done all those significant things I was sure I would have time and energy for once I was turned loose.***

So when the time for real retirement as usually understood came along, in a sense all I had to do was change clothes. At the same time, my giddy first thoughts were of escape. I was on my own without any direction from above, however benevolent, and without any set schedule of meetings or engagements — no supervision (other than domestic), no more subordinates (at least official ones) to try to lead and guide, no more committees (chief bane of the active life). Also, I could at last immerse myself as I might choose in playful pastimes and in the wonderful self-indulgent diversions known as hobbies. I could fish without waiting for office hours to end or hurrying back to keep this engagement or that. I could hack around the golf course every day if I wanted to. I could now, as means afforded, flit about the earth and observe its wonders at close first hand, savoring their shades and textures. I could now dance the night away as I might please. It might be that I could at the same time, to keep my conscience in check like the good person I ought to be, fit in some part-time useful service to mankind. And now I could, like small boys and girls, think long thoughts without being pushed to make anything of them except poems never written down. Why should they be?

But then too, thinking at last more soberly, I was indeed free to continue with much of what I had been up to during most of my professionally involved life. I was at last at liberty to pursue, if you will, the life of the mind without fretting necessarily about adapting my explorations and reflections to the dictates or whims of others. At the same time, something out on the edges vaguely troubled me. For the old harness, a hardened strapping of discipline that had imposed the schedule, the setting, and the pace of my work had been suddenly stripped away. There was plenty of study and writing left to be done, but now I must generate my own demands and assume the burden of my own authority over myself. I had become, ironically, my own dependent.

So how, actually, has it all worked out?

I have few complaints here at this point of 9 years beyond official retirement. Though little has been accomplished in any sort of modified continuation of my former career interests, I have found contentment in and realized solid profit from other activities and preoccupations — and I have learned long since to live fairly comfortably with my excuses for not driving hard to get done all those significant things I was sure I would have time and energy for once I was turned loose.

I have already mentioned (and I meant to do so gratefully) the essential resources for retirement that were built up during most of my earlier life. I have proved for myself that the way one lives in retirement — always a combination of being and doing — will represent, if basically satisfying, a modified extension of the previous active life. If this seems an obvious conclusion that could just as well remain unmentioned, then call to mind those who have found retirement a great bore and burden and who regret the choices they have made of ways to spend their remaining years. Boredom has never been a problem with me, for so far I have never found myself without something of absorbing interest to do.

Reading and scribbling have inevitably taken first place among the things I like most to do. I would find it entirely possible to live at ease without the aid of electronic media, though I readily recognize and approve of what these have meant to so many others among my peers. I do not read nearly so much as I used to, and certainly my reading is more general and superficial than for-

merly. Serious study, regrettably, has gradually lost its earlier compelling attraction; and I have come to find that scholarly writing, the demands of which were always rigorously taxing in my case, is less inviting. I would hardly dare by this time to undertake any such work beyond the flimsiest character. Yet the driving urge to get something down on paper and get it right has not lost its force so far as I can tell. A pecular private happiness comes my way whenever I manage to construct what I judge to be a good paragraph or a good line. So if I am forced or beguiled away from my reading-writing chair for too long, I become restless and sour until I can return.

Along with the above, and almost as important to me, is that which is more strictly but yet haphazardly defined as the life of the mind. Undoubtedly a reflective inclination developed with me a long time ago in the study hall and library. I have never got over it. Without trying to label it as some kind of systematic philosophizing, I do like to ponder and try to make sense of things in the abstract. My profession required that I should be a questioner of propositions, one committed to viewing things in context and perspective and in carefully judged proportions, attempting — as Matthew Arnold once said, I believe, of Socrates — "to see life clearly and see it whole."

It seems true, at least in handling my own retired existence, that a fair amount of mental exertion of the kind just mentioned is strengthening and healthful in a general way. To touch briefly upon my own specific efforts to understand the way things work more or less universally and permanently, I appear to think, for whatever complex of reasons, in terms of reconciliation. Everything has its opposite — in human affairs, in the natural world about us, and I judge in dimensions beyond our present full comprehension. Dynamic activity is taking place all the time as opposites confront one another and either reject any embrace or strive for and sometimes attain congenial melding.

Life and death appear to be for many of us forever irreconcilable. Yet as I watch the workings of nature and the seasons turning, bringing death to life and then transforming death into life over and over again in an endless miraculous process of ebb and flow, I feel that I am being taught an unassailable truth about all things. The finite would seem to have the same kind of connection with the infinite, a sort of working back and forth. The factual is in constant debate with the fanciful or imaginative, and poetry must make its insistent claims always upon dry logic and cold reason — and vice-versa. What I try to understand about science, soft or hard, and theology does not fail to suggest to me in these so swiftly running final years an ultimate reconciliation of the opposites they may often appear to be.

Well — others may not be expected to view life or "reality" exactly as oneself does, even though many think or feel somewhat alike and thus come to make up parties, denominations, schools, etc. But my essential point is that some serious set of conclusions or beliefs about such fundamentals, or indeed just the persistent effort to arrive at them, is in my view especially beneficial to those who at last have the lucky opportunity to reflect, to sum up, to make sense of things.

But after all, as John Keats once said, "Philosophy will clip an angel's wings," and I am happy for believing that this is so if reflection by itself is given too much weight. There are many other things of refreshing value in retirement available to me when thought becomes a chore. The arts, for example, are a genial aid to existence in greater degree than we might imagine — at any stage of our lives. Combinations as they are of the constructing imagination and the raw stuff within us and about us, they complement without tiresomeness whatever way we look at life and understand it.

Poetry for me is the mother of all art. It is the one that I seem to comprehend most readily and enjoyably. I regret that the plastic arts and music have never quite fully gripped my spirit or fired my fancy as I feel they must do for those more fortunately attuned to their distinctive appeals. I remember only too well the day I gave up piano lessons for camping and baseball as well as the time when I was informed by a correspondence school that, sadly, I was wasting my small investment in trying to learn how to draw. But long since I have come never to doubt the wholesome and most practical usefulness of all the arts to everyday living.

The outdoor world has had lively appeal for me from the beginning and still has. There was enough of the rural, of the Deep South frontier, in my upbringing to ensure magnetisms and pas-

sions for which I had no adequate explanation until I learned from the poet William Wordsworth how to define them. Every one's imagination is formed and channeled by some dominant combination of shaping elements. In my case, the middle-Georgia small town of the early twentieth century, with its surrounding of wooded hills, lively clear waters, and slowly tended fields and gardens was abundantly filled with matter for feelings as well as mind to feed upon. I easily remember the smells, the texture, and the taste of that wonderful time, and in my foolish wiser time I instinctively try to relive it — and I believe it is good for me to do so. Sooner or later I have to get out and go with sunshine and wind, and the more often the better. When I have the chance to go fishing — though the passion I once knew that kept me long awake the night before a day on the water has mostly dissipated — I still find delight in checking my equipment, trying to get back the feel of a casting or fly rod, and pitting myself eagerly against the lunging rise of a fish.

Outdoor games still are my preference over inside pastimes. Regardless of my ineptness, I even yet would rather, if at all possible, get physically engaged in competition. I am undoubtedly among the least-talented of golfers, but the game holds magic for me that I cannot resist. So I try to play two or three times a week if I can find someone willing to play with me. As depressing as my game may be to others, my hopeful imagination preserves for me the illusion that I shall just any day finally "get the hang of" the way this most subtle of outdoor games should be played.

I take simple boyish delight in these pastimes and engage in them primarily for that reason alone. But I am a firm believer in the intimate connection between enjoyable and controlled physical activity and the mental-emotional sides of one's life, the importance of which for me has already been mentioned. We are all such a wonderful mix of both animal and human.

While a little yard-and-garden work usually goes a long way with me, I like the idea of it and take vicarious satisfaction from the dedicated involvement of some of my friends and neighbors. I can use most of the garden tools if driven and have been known to become briefly absorbed in this useful recreation. I may add that I follow, mostly by way of television but with considerable zest, other outdoor amusements, My favorite among these is baseball since this was the first sport I came to know in the particular little town of my early childhood.

Although not ebulliently gregarious, I am by nature a sociable individual and find the company of genial spirits elevating and distracting. Unless there are things that I can ill afford to leave behind, going somewhere and losing my self-consciousness for a time in cheerful associations nearly always leaves me better off. The contact with other temperaments, the informal exchange of thoughts and feelings, and the gleaning of the kind of information to be expected in social situations have a natural appeal that I interpret as a sign of well-being.

Among my most vital personal needs in retirement is the simple, basic warmth and comfort of more intimate companionship. Many of us have to live alone and are to that extent, I think, seriously deprived. There are of course those among my general age group who seem to manage their single state very well, but this way is not for me. A first marriage that happily endured for almost 50 years was a most fortunate one that gave me the sort of support and comfort that I required for effective work and a balanced way of life otherwise. A second marriage to one also left alone has turned out to be just as indispensable in these respects. The larger family circle that this has made possible has increased our sense of security and given us grateful contentment.

Travel is for many, to the extent that it can be afforded without strain, the best way to go in retirement, and we all know those who are on the go incessantly and seem never to tire of moving almost continuously about the world or good parts of it. Certainly times come when one needs to abandon home-bound needs and demands and to experience a change of environment. Variety may not always prove to be the spice of life, but monotony for most of us gets to be an illness. I myself sometimes think that I enjoy the idea of travel more than the actual going itself, but there are a number of favorite spots and areas away from home here and abroad that I look forward to seeing again or visiting for the first time. I can't imagine ever tiring of London, and one day I would like to visit Rome and Paris and some provocative far place beyond the setting sun. I am, however, too well-rooted in Georgia soil ever

to stay away for very long; and when I one day (far ahead, I hope) reach the point when I can no longer stir around, this is where I want to stay with no more roaming.

Before turning toward some kind of conclusion to this self-propelled invasion of my private retreat, I must say something about the use and value of religion to me, worldly person though I may be in so many ways. I have to say directly, along with the poet S. T. Coleridge, that it is a fundamental requisite for me —

> To walk together to the kirk
> With a goodly company —
> To walk together to the kirk,
> And all together pray,
> While each to his great Father bends,
> Old men, and babes, and loving friends
> And youths and maidens gay.

I was long ago brought up severely to go this way, and despite far-ranging excursions in other directions and much loitering along the path prescribed, I find that I must hold to it steadily now. And my way of thinking, as earlier described, demands it. Such matters are, I would agree, resistant by their very nature to the fathoming of reason as we approach the bottom line. But more and more for me, the voice of the heart speaks more insistently than the dispassionate one of calculation.

It would appear, I am sure, that for the most part I have enjoyed my retired situation and have fared far better than many so far in my experience of it. I am nonetheless aware of certain problems that have to be dealt with as time moves along. Our mortality crowds upon us more and more, and it can frighten us sometimes with an ugly face indeed. Time's "winged chariot" is on its swift move as never before. Even so, boredom and sighing nostalgia for some things forever gone are too-familiar afflictions hard to bear. The built-in slippages and slackening of nerve and fiber that nature demands with accompanying enfeeblement of spirit cannot be escaped unless we are suddenly taken away, and much of our impoverishment often brings the feeling that all is flying apart, that — as W. B. Yeats suggests — "the center cannot hold." We may be forced to think too much about the bludgeonings of fate and chance.

Apart from these melancholy spectres there are, to appeal to our weakness, at least two different, and tempting, ways of escape familiar enough to us. One is Dylan Thomas's impassioned suggestion that we should "Rage, rage against the dying of the light." The other is sweetly subtle and beguiling — the merry philosopher's "carpe diem," making every day insofar as possible one of wine and roses in the pursuit of self-indulgence to its farthest limits.

***Our mortality crowds upon us more and more, and it can frighten us sometimes with an ugly face indeed. . . . The built-in slippages and slackening of nerve and fiber that nature demands with accompanying enfeeblement of spirit cannot be escaped unless we are suddenly taken away. . . .***

How do we deal with these realities? There is, I am sure, no very reliable general set of prescriptions — all cases being, as I feel, quite different. So how do I attempt to deal with them for myself?

Most of my answers have been provided or implied in my accounting already rendered. In sum and finally, however, I keep saying to myself:

Accept life as it is given and as circumstances beyond your control have dictated. Always go with the grain — never anybody else's. Stay absorbed in whatever brings true delight — and let time run as it may. Cultivate a thankful spirit for the good things banked up from the past. Clean out any dregs of guilt left over from the cluttered mess of old bad times and know that there are reliable aids to help take care of them. Try incessantly to maintain balance, proportion, and perspective. Remember that the soundest possible physical well-being is a *sine qua non*, and that good conditioning applies as much to mind and spirit as it does to body. Believe that genuine, honest religious faith makes completely good sense. Accept John Keats's view that, "The poetry of earth is never dead." Don't take Dylan Thomas too seriously and note carefully, while having a real good time, the holes in "carpe diem." ■

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# Common Techniques for Overpaying Estate Taxes

William C. Griffith, Jr., Don L. Waters

***It is amazing that people will accept investment risks in seeking greater-than-guaranteed returns or take aggressive tax positions in order to reduce income taxes, yet often fail to approach their estate planning with the same intensity.***

THE TYPICAL, HIGHLY PAID individual has always been interested in tax planning and the arrangement of his or her financial affairs so as to minimize taxes. Even the massive changes recently enacted in the Tax Reform Act of 1986 will not diminish one's desire to be aware of potential tax-saving strategies. The strange thing about this emphasis on tax planning is that many people focus only on income taxes and ignore the significant impact of estate taxes. The only logical explanation for this lack of attention is that many people do not understand the cost/benefit ratio of estate planning.

For an individual who has accumulated a sizeable net worth and/or life insurance portfolio (sizeable being defined as at least $600,000), the consequences of a lackadaisical attitude toward estate planning can result in a tax liability that is *significantly* higher than necessary. The purpose of this article is to elevate the awareness level of the layman of the devastating effect of poor estate planning. This will be done by reviewing some fairly common techniques found in many estate plans that will assuredly result in excessive taxes.

### Simple Wills

With all the emphasis attorneys have placed on revising wills in the wake of previous tax law changes, you would think that no individual with a large net worth would still have a simple will (one which leaves all assets to the surviving spouse). Not so; I recently reviewed the will of an individual with a substantial net worth only to find that it specified that essentially all assets were to go to the wife.

Individuals typically want the surviving spouse to receive most of the assets at the death of one spouse. This is easily accomplished by stating such desire in the will. One advantage of such a bequest is that there is no tax due on assets left to a spouse. The problem, however, with a simple will is that it does not take advantage of a tax credit that is available (the credit offsets the tax on assets, up to $600,000, that are not left to a spouse or to charity). The result being that the tax due at the death of the surviving spouse may be significantly higher than necessary. (The use of a qualified disclaimer by the surviving spouse can correct the over-funding of the marital deduction; however, relying on this technique requires critical atten-

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tion to detail and would result in certain assets being unavailable for the support of the spouse.)

For example, assume a husband with a $1,200,000 net worth dies, leaving the entire estate to his wife. Further, assume that at the death of the wife, the assets are still intact. In such a situation, the total value (plus appreciation) is included in the wife's taxable estate. The tax at the wife's death would be approximately $235,000. In a properly structured will using the unified estate tax credit, at the death of the wife the tax could have been approximately zero. By using the "simple will," estate taxes are obviously overpaid. It should be noted that this is not a mere deferral of taxes but a permanent savings.

This credit can be used by changing the will to provide that certain assets are to be left to a trust rather than to the spouse. The terms of such a trust can provide a great deal of flexibility in making the assets available for the needs of the spouse.

### All Assets in Husband's Name

Fortunately, the above-mentioned technique is not often employed in estate planning for high net worth individuals; however, the frequency with which poor planning surfaces in the area of ownership of assets is frightening. It is fairly common to see situatioins where the only assets, excluding personal property such as jewelry, etc., which are in the wife's name are joint bank accounts. The residence may or may not be jointly owned.

This bunching of assets in the husband's name creates a significant estate planning problem: the possible failure to use the tax credit, which is available to the wife's estate, in the event she predeceases the husband. The effect can be illustrated using the preceeding example. If the $1,200,000 were equally owned by both spouses and the wills were properly drawn, the combined tax in both estates would be $-0-; however, if all the assets are owned by the surviving spouse, the tax would be $235,000.

The lifetime transfer of assets to the wife must be co-ordinated with her will so that the assets will not pass back to the husband at her death.

### Life Insurance Owned By Insured or Spouse

Having reviewed the financial affairs of quite a few individuals, it seems that many people are concerned over the estate aspects of whether the residence should be in his, her, or both names; however, comparatively few seem to have given much thought to how life insurance should be owned. The point is that the ownership of life insurance (simply because of the amount typically involved) is often one of the more important issues in estate planning.

Typically, the husband is the insured and the proceeds are payable to the wife so as to be available for the family's support. The typical ownership arrangement is for either the husband or the wife to be the owner. In this typical situation, the unspent portion of the proceeds remaining at the wife's death become part of her estate and may be taxed at rates as high as 55%.

An alternative which would eliminate the tax related to the insurance proceeds at the death of either spouse, but which would still provide for the support of the family, is to name a trust as the owner *and* beneficiary of the policy. Although such a trust requires a legal document separate from the will, and the irrevocable transfer of the policy (the main concern here being that a change in family relations, coupled with the inability to obtain new insurance could affect the insured's flexibility in determining who benefits from his insurance), the benefits of this form of ownership can be a tremendous reduction in taxes.

For example, assume a husband has a $1,200,000 net worth plus $1,000,000 of life insurance which he owns and which is payable to the wife. In addition, assume that the husband's will takes advantage of the available credit and, upon the wife's subsequent death, all of the assets are intact. In this situation, the tax at the wife's death would be $408,000 greater than if the insurance had been owned by a trust.

### Overstating Value for Business Buy-Sell Agreements

A common method for partners or shareholders of a closely-held corporation to provide for the orderly transfer of the business interest at the death of one of the partners/shareholders is to have an agreement that specifies a predetermined price that the remaining owner will pay to the estate of the deceased in return for the ownership interest held by the estate. Insurance is typically purchased which will provide the necessary funds.

***The cost/benefit ratio of inadequate estate planning is impressive: significant cost for very little, if any benefit.***

In reviewing buy-sell agreements and the financial statements of the businesses to which these agreements relate, it is amazing how often the pre-determined value is much higher than the apparent value of the business. It seems as though the value is thought of more in terms of how much can be justified (after all, insurance will provide the funds and the business is paying the premiums) rather than in terms of what value would be placed upon the business in the event an owner simply wants to sell out during his lifetime. (Although the pre-determined price is supposed to cover all situations where ownership interests are to be sold, it is not uncommon for a lower price to be negotiated

when one party simply wants out.)

The problem with this approach is that whatever value is put on the business (unless it is unreasonably low) will probably be included in the estate of the deceased owner and be subject to taxes. A more reasonable approach seems to be to select a realistic value, one that might also be used in the event of a lifetime transfer of ownership. If this approach leaves an individual's estate with insufficient assets, insurance can be purchased separate from the business, preferably within a trust. The effect will be to remove unnecessary assets from the taxable estate.

For example, assume that a husband is 50% owner in a medical practice, that both husband and wife each own $600,000 of other assets and that both wills are designed to use the available credit. Assume that the value of the practice, adjusted for doubtful accounts receivable, appears to be $90,000 (50% of which would be $45,000). Further assume that the buy-sell agreement, which is funded with life insurance, specifies that the value of the 50% interest is $100,000. The effect of over-stating the value, when compared to correctly stating the value and placing the remaining insurance in a trust, will be unnecessary taxes of $20,350. (As ludicrous as this example seems, it is not uncommon to see inflated values in buy-sell agreements.)

### Summary

It is amazing that people will accept investment risks in seeking greater-than-guaranteed returns or take aggressive tax positions in order to reduce income taxes, yet often fail to approach their estate planning with the same intensity. The ironic thing is that often substantial sums can be saved without taking *any* risk.

As the preceeding examples illustrate, the cost/benefit ratio of inadequate estate planning is impressive: significant cost for very little, if any, benefit. ■


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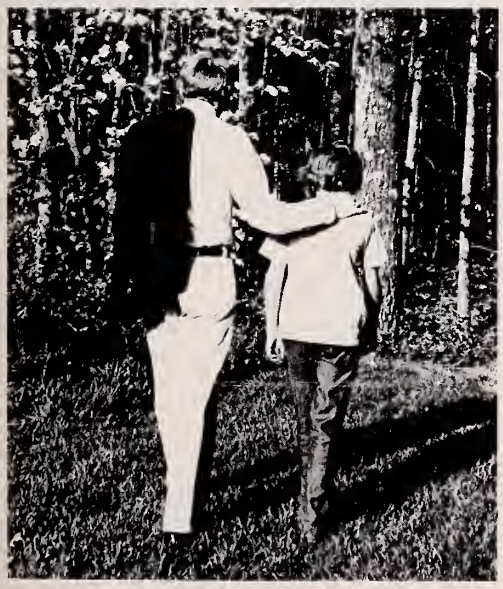

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The Army Reserve understands the time demands on a busy physician, so you can count on us to be totally flexible in making time for you to share your specialty with your country. We'll arrange your training program to work with your practice.

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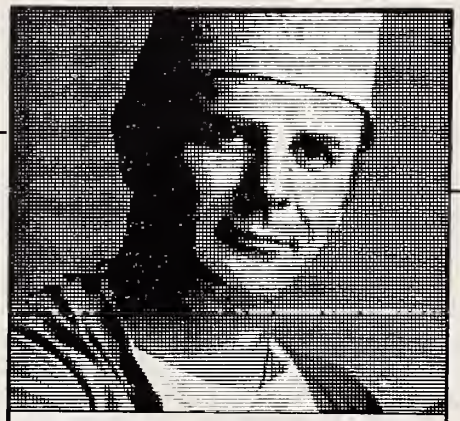

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# Legislative Remedies to the Liability Crisis

Charles D. Hollis, Jr., M.D.

WE CAN ALL AGREE that the recent liability crisis has been a critical issue for every single man, woman, and child in this state. Medical liability premiums continue to escalate for physicians and other health care providers as losses continue to march upward. While the huge rate increases have slowed for many other kinds of protection, the high cost of liability premiums is still causing a serious financial burden for all insurance buyers, including small businesses, large corporations, professionals, nonprofit organizations, and municipal governments. Most people have come to recognize this as a serious problem that is affecting society in general as well as these particular groups. As a result, government representatives on both the state and federal level have begun to take action.

The federal and state governments can and do play a role in guiding public response to this problem. In the past, the federal government entered into limited areas of liability having a nationwide or industry-wide impact, such as environmental liability, nuclear liability, and certain specialized problems such as immunization liability. For now, let's set aside the issue of federal involvement and focus on state efforts at tort reform. We will return to a discussion of the role of Congress.

Tort law, including the area of professional liability, is governed by state statutes and courts. Laws regarding informed consent, rules of evidence, trial procedures, jury instructions, and other important procedural and substantive issues have been determined by state rather than federal laws. Accordingly, many states have been active in tort reform, especially in the area of medical professional liability.

The most common issues considered by state legislatures have been the following:

1. Disclosure of Collateral Sources — letting the jury know what amount of compensation a plaintiff has already received from other sources for the same injury.
2. A Cap on Non-economic and Punitive Damages — limiting compensation for non-economic losses such as pain and suffering and for punitive damages. Caps do not affect compensation for medical expenses, past or future wages lost, and other expenses incurred.
3. Structured Settlement of Large Cases — providing that losses, usually above $100,000, may be paid over time, with appropriate consideration of immediate economic need.
4. Abolishment of Joint and Several Liability — apportioning the plaintiff's award among defendants according to the degree of fault of each.

A recent study by Insurance Services Office, the national rating organization for the insurance industry, describes the effects of tort reform enacted or under consideration in 24 states.[1] The study concluded that changes effected or made in tort law in some 15 states in 1986 were likely to have a significant impact on indemnity payments in those states but only in a relatively narrow range of claim situations. The study concluded that three specific changes in tort laws could result in considerable savings in indemnity losses in a broad range of cases. These are: (1) complete abolition of joint and several liability; (2) substantial relaxation of the collateral source rule; and (3)

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a cap of $250,000 on non-economic loss.

A number of states, including Georgia, have passed various aspects of tort reform in 1986 or 1987. The impact on premiums will vary considerably according to the specific provisions passed in each state. Furthermore, the benefits of any tort reform cannot be fully realized until the state's laws withstand constitutional challenges brought against them. Of course, any tort law changes apply only to claims arising or filed after the new law goes in effect, and not to pending claims. In short, there will be a time lag in each state with respect to the impact of tort reform on insurance premiums. However, certain studies indicate the prospects are good that premiums will start to moderate in those states passing meaningful reform, such as Georgia.

**Table 1 — Comparison of Insurance Premiums: Between Tort Reform and No Tort Reform States[1]**

| | *Medical Liability Insurance Premiums ($1,000,000/$3,000,000 Policy)* | | |
|---|---|---|---|
| | *California[2]* | *Georgia[2, 3]* | *Ratio GA-CA* |
| **1976** | | | |
| **Internist** | $ 2,243 | $ 922 | .41 |
| **Family Practitioner, OB & Surgery** | 7,050 | 2,640 | .37 |
| **General Surgeon** | 7,050 | 4,342 | .62 |
| **Obstetrician** | 10,580 | 5,192 | .49 |
| **Neurosurgeon** | 10,580 | 6,894 | .65 |
| **1986** | | | |
| **Internist** | $ 3,700 | $ 4,620 | 1.25 |
| **Family Practitioner, OB & Surgery** | 14,432 | 12,400 | .86 |
| **General Surgeon** | 16,508 | 22,896 | 1.39 |
| **Obstetrician** | 28,220 | 37,799 | 1.34 |
| **Neurosurgeon** | 30,112 | 47,491 | 1.58 |

1. Key Elements of California Tort Reform enacted in 1975: A. $250,000 cap on non-economic loss. B. Structured settlements of future damages. C. Collateral source benefits disclosure. D. Sliding scale for attorney fees.

2. California rates are NORCAL Mutual Insurance Company net rates for San Francisco; Georgia rates are St. Paul rates statewide for 1976 and MAG Mutual Insurance Company rates statewide for 1986; St. Paul Fire & Marine rates in Georgia are approximately the same as MAG Mutual rates.

3. In 1976, $1,000,000/$3,000,000 was not being written in Georgia; the highest limits were $1,100,000/$1,300,000. However, the comparison is still valid given that the difference between the rates for those two coverages is minor (6%).

***The benefits of any tort reform cannot be fully realized until the state's laws withstand constitutional challenges brought against them.***

Patricia Danzon, one of the leading experts in the field of medical professional liability, has studied the effects of tort reform. She examined medical malpractice claims closed during the full decade 1975-1984. Data were gathered from most of the U.S. insurers with a significant market share at any time during the decade, covering approximately 100,000 physicians. Forty-nine states were represented. She concluded:

> Caps [$250,000] on awards have reduced severity (average amount paid per claim) by 23%, from what it otherwise would have been.
>
> Statutes permitting or mandating the offset of collateral benefits reduced claim severity by 11% to 18% and also reduced claim frequency (claims per 100 doctors) by 14%.
>
> Arbitration statutes appear to have increased claim frequency but reduced average severity. The net affect appears to be an increase in total claim costs.[2]

Perhaps the only example of meaningful tort reform conclusively tested is the experience of California. In 1976, California became the first state to pass significant tort reform, and the legislative changes made there withstood constitutional challenges. Key elements of California tort reform for medical liability include a $250,000 cap on non-economic loss; structured settlements of future damages; collateral source benefits disclosure; and a maximum sliding scale fee for attorneys. Table 1 provides a comparison of medical professional liability premiums for California and Georgia for the years 1976 and 1986. In 1976, net rates in California were two to three times higher than those in Georgia. Ten years after tort reform was passed in California, the situation is reversed. In 1986, net rates in Georgia averaged up to 50% higher than rates in California.

The trend continues for 1987. The Doctors Company, one of the four California physician-owned professional liability insurance companies, has recently set rates for 1987. It insures nearly 11,000 doctors, 25% of the doctors in California. Rates in 1987 will show a 5% increase for Northern California, less than 1% increase for the Los Angeles area, and 3% increase for the San Diego area. Rates in Georgia increased an average of 30% for 1987.

**Table 2 — Georgia Leads the Country in Punitive Damage Awards**

| | | *State Court Jury Verdicts* | | | |
|---|---|---|---|---|---|
| *Year* | *Metro County/State* | *Number Verdicts* | *Plaintiffs' Verdicts* | *Punitive Awards* | *Percent* |
| 1981-83 | Maricopa, AZ (Phoenix) | 1,091 | 619 | 81 | 13.1 |
| 1981-83 | Los Angeles, CA | 1,691 | 942 | 81 | 8.6 |
| 1981-83 | San Diego, CA | 296 | 137 | 4 | 2.9 |
| 1981-83 | San Francisco, CA | 396 | 231 | 21 | 9.1 |
| 1982-83 | Fulton, GA (Atlanta) | 364 | 204 | 27 | 13.2 |
| 1982-83 | DeKalb, GA | 142 | 82 | 14 | 17.1 |
| 1982-83 | Cobb, GA | 59 | 37 | 8 | 21.6 |
| 1982-83 | Cook, IL (Chicago) | 1,686 | 986 | 22 | 2.2 |
| 1983-84 | Dupage, IL | 162 | 95 | 4 | 4.2 |
| 1983-84 | Will, IL | 142 | 85 | 5 | 7.1 |
| 1981-83 | New York, NY | 1,974 | 1,224 | 20 | 1.6 |
| 1981-83 | Nassau, NY | 449 | 198 | 6 | 3.0 |
| 1983 | Suffolk, NY | 341 | 185 | 8 | 4.3 |
| 1984 | Multnomah, OR (Portland) | 137 | 84 | 5 | 5.9 |
| 1981-84 | Harris, TX (Houston) | 1,599 | 913 | 123 | 13.5 |
| 1983 | Dane, WI | 15 | 8 | 1 | 12.5 |
| 1983 | Milwaukee,WI | 57 | 38 | 3 | 7.9 |
| 1983 | Racine, WI | 26 | 19 | 2 | 10.5 |

Source: *American Bar Association Journal* — August 1, 1986

The California tort reform measures are having a significant impact on the average size of losses. The Doctors Company in California reports that it has recorded only one loss of more than a million dollars since 1976. Company officials are aware of no other company having more than two claims greater than a million dollars since 1976. The other significant factor reported was that after the Supreme Court upheld the California Reforms, several major plaintiff firms discontinued handling medical malpractice suits. This information proves meaningful tort reform does have substantial impact on insurance premiums.

### Georgia and Its Tort Reform Act

The 1987 Georgia General Assembly passed the Georgia Tort Reform Act of 1987 and the Medical Malpractice Reform Act of 1987. This is the most significant tort reform package ever passed in the State. The major provisions of the new act are outlined below:

1. Directors and Officers of nonprofit entities are immune from negligence except for willful or wanton misconduct.
2. Evidence of any and all compensation, except life insurance, available to plaintiff is admissible to the jury.
3. Except in product liability cases or in cases where it is proven that the defendant acted with the specific intent to cause the harm, any award of punitive damages may not exceed $250,000.
   A. Punitive damages may be awarded only in cases in which it is proven by "clear and convincing" evidence.
   B. If punitive damages are sought, the jury determines liability damages first. Then trial is immediately recommenced on the issue of punitive damages.
   C. Punitive damages cannot be awarded to compensate a plaintiff but solely to punish, penalize, or deter a defendant.
   D. In a products liability case, only one award of punitive damages can be given, regardless of the number of cases arising from the negligence. Although there is no limit on the amount of the punitive awarded in this case, 75% of the award goes to the state.
4. When the award is clearly inadequate or excessive, if the parties refuse to accept the amount determined by the court, the court may order a new trial (as to damages only).
5. The plaintiff may collect his entire award from any one of the several defendants unless the plaintiff himself was "to some degree" responsible for his injury. In such a case, the jury may apportion fault among the defendants whose negligence is greater than that of the plaintiff. If apportioned, each defendant is liable only for his share.
6. A minor who has not attained the age of five (5) years shall have two (2) years from his/her fifth birthday to file a medical malpractice suit for any cause of action which arose before age five (5).
   A. In no event may an action for medical malpractice be brought after the tenth birthday of the minor if the negligent act or omission occurred prior to the minor's fifth birthday.
   B. In no event may such an action be brought after five years from the date of the negligent act or omission occurred.
   C. This statute does not apply

where a foreign object is left in a patient's body.

7. Plaintiff must file an affidavit of an expert simultaneously with the complaint. The affidavit must specifically set forth at least one negligent act or omission claimed to exist and the factual basis for each such claim.
8. Except for gross negligence or willful misconduct, health care providers shall not be liable for injuries arising out of voluntary charity work done at the request of a hospital, public school, non-profit organization, or governmental agency. Professional service must be provided "without the expectation or receipt of compensation."

Specific items in the act directly address important issues in Georgia's liability picture. For example, the provision on punitive damages will affect the growing number of punitive damage cases in the state. Metro Atlanta leads the country in punitive damages awards as shown in Table 2. This act gives us hope that we will be able to slow the increase in professional liability premiums in Georgia.

These provisions have already helped to reduce the increase in insurance premiums for many Georgia physicians. MAG Mutual's actuaries reported a 25-40% rate increase range for 1987, based on analysis of the loss data. The Company filed only for an overall net average increase of 25%. In part, the reasoning for taking the low end of the range is the expected moderation of losses attributable to tort reform.

### Congress and the No-Fault Concept

Congress has debated the idea of a no-fault system for medical professional liability. This system would resemble the worker's compensation programs now in place.

The idea behind the no-fault approach is to create a more reasonable and fair system so that most of the funds paid go to the injured patient rather than being consumed in the litigation process. Studies indicate approximately 60% of each dollar spent for medical liability insurance goes to pay litigation and administrative costs and plaintiff's attorney's fees rather than to the patient.

***The idea behind the no-fault approach is to create a more reasonable and fair system so that most of the funds paid go to the injured patient rather than being consumed in the litigation process.***

In Congress, the Moore-Gephardt Bill (H.R. 3084, the Medical Offer and Recovery Act) is pending before the Ways and Means Committee and has been under consideration for the last several years. This bill proposes encouraging prompt offers of settlement in medical malpractice cases and limiting recoveries to economic damages. Will this measure help in the availability and cost of liability insurance?

The proposal calls for some major changes in the current tort system, but the anticipated effects of those changes undoubtedly need to be analyzed carefully. For example, some insurance industry observers believe that a "no-fault" system may bring to light many injuries occurring in the health care system that currently are being overlooked because of the cost and difficulty involved in prosecuting them. These people believe that even though the proposed system might be less expensive for known claims, "unknown" claims may surface, causing expenses to soar.

Another approach can be found in recent state legislation. The State of Virginia passed a law removing only the most severe cases of neurologically damaged infants from the tort system. The law is extremely narrow in its scope because it applies only to "birth-related" neurological injury defined as:

> "any injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital which renders the infant permanently non-ambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living."

The law provides for a state-run pool funded by annual assessments from physicians and hospitals who agree to provide obstetrical services to patients eligible for Medical Assistance Services and indigent patients, supplemented by contributions from all insurance carriers licensed to write liability insurance, if necessary.

With such limited scope of authority, the new law is not expected to reduce premiums for obstetricians by very much. It is, however, a first step in alternatives to civil tort law resolution of medical liability cases.

### The Effect of Tort Reform on Insurance Premiums: Medical Liability

*A Word of Caution*

A percentage reduction in future claim frequency or severity does NOT translate into a similar percentage *savings* from current insurance premiums.

Premiums are derived from losses plus insurance company expenses. Losses have two components — frequency (claims per 100 doctors) and severity (the average amount paid per claim). To lower premiums you must reduce the total amount of losses paid. If the sum of the amounts paid per claim (severity) and the number of claims paid (frequency) declines, then insurance premiums also will fall.

***In 1976, California became the first state to pass significant tort reform, and the legislative changes made there withstood constitutional challenges . . . (and) are having a significant impact on the average size of losses.***

However, it is probably unrealistic to expect that the total amount insurers pay in claims will actually decline from today's levels for many reasons: inflation increases claims costs, more claims are filed every year, courts add new coverage interpretations to liability policies, expert witness and defense attorney fees are rising, hospital care costs are climbing steadily. Many other factors affect the total claims amount paid by insurers each year.

**Tort reform will produce a savings on what premiums might have been in Georgia in the next few years without reform.**

### Conclusions

Tort reform is gaining momentum across the country. Although the results are still inconclusive, meaningful reform can definitely have an impact, especially after it withstands constitutional challenge.

One basic insurance rule is that premiums are composed of losses — frequency and severity — plus the costs of operating the insurance company. Over the long run — through business cycle after business cycle — premiums will follow losses. There will be temporary deviations, but over the long run, premiums will track losses.

Therefore, tort reform is not for the insurance companies. They can and do raise their prices and limit coverage in order to maintain profitability. When they are prevented from raising premiums to levels dictated by losses, they simply withdraw from the market and redeploy their capital in the markets where they have a reasonable chance of making a profit.

**The purpose of tort reform is to moderate or, hopefully, flatten the upward trend being generated by the growth in losses so the people of Georgia can afford the protection which insurance provides and can have the services which insurance makes available.** ■

### References


1. Business Insurance, May 11, 1987.
2. Danzon P. The effects of tort reform on the frequency and severity of medical malpractice claims. March, 1986, Institute for Civil Justice; The Rand Corporation.

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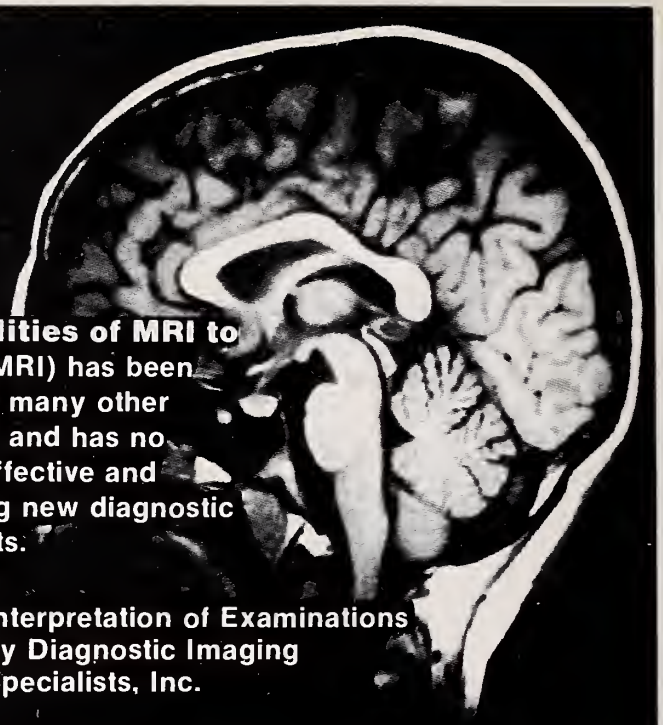

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Registration for the Scientific Assembly allows a physician to attend any and all CME programs held during the weekend. To register for these scientific meetings, please complete the registration form inserted in this *Journal,* detach it from the hotel reservation form, and mail it with your registration fee to the MAG office.

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**Hal Nelson, M.D.**
Director of Division of Allergy
National Jewish Hospital for Immunology & Respiratory Diseases
**James Bonner, M.D.**
Associate Professor of Medicine
University of Alabama Birmingham
**Karen Sumers, M.D.**
Ophthalmologist, Atlanta
**Ronald Tifton, M.D.**
Assistant Clinical Professor of Medicine
Emory University, Atlanta

## FRIDAY, NOVEMBER 20

12:00- 1:20 LUNCHEON (SPONSORED BY FISONS)
Allergy and Immunology Society of Georgia

1:30- 1:35 WELCOME
Margaret Guill, M.D., President
Allergy and Immunology Society of Georgia

1:35- 1:40 INTRODUCTION
Nathan Segall, M.D.

1:40- 2:20 ANAPHYLAXIS — MECHANISMS, CLINICAL FEATURES AND TREATMENT
James Bonner, M.D.

2:20- 2:40 SKIN TESTING: PITFALLS IN THE DIAGNOSIS OF ALLERGIC DISEASES
Hal Nelson, M.D.

2:45- 3:05 ROSACEA OPHTHALMIA
Karen Sumers, M.D.

3:05- 3:35 COFFEE BREAK (SPONSORED BY GREER LABORATORIES)

3:35- 4:15 IMMUNOTHERAPY, AN UPDATE
Ronald Tifton, M.D.

4:15- 5:00 INHALATION THERAPY IN THE TREATMENT OF ASTHMA
Hal Nelson, M.D.

5:00- 5:45 BUSINESS MEETING
Members of the Allergy and Immunology Society

We gratefully acknowledge the generosity of Fisons Pharmaceuticals in sponsoring the Society luncheon, and of Greer Laboratories in sponsoring the coffee break.

# CHEST DISEASE

## ALL DAY FRIDAY & SATURDAY MORNING

## GEORGIA THORACIC SOCIETY

*Program Chairman:*
**Eric G. Honig, M.D.,** Atlanta

*Guest Speakers:*
**Christopher Fanta, M.D.**
Brigham and Women's Hospital
Harvard Medical School
Boston

**Janet Maurer, M.D.**
University of Toronto

**Diane Stover, M.D.**
Memorial Sloan-Kettering Cancer Center
Cornell University School of Med., N.Y.

## FRIDAY, NOVEMBER 20

*Presiding:*
**Eric G. Honig, M.D.,** Atlanta

9:00- 9:45 BRONCHOALVEOLAR LAVAGE
Leslie Watters, M.D.
Decatur

RESEARCH AWARDEE OF THE GEORGIA LUNG ASSOCIATION

9:45-10:30 IMMUNOLOGIC ASPECTS OF ASTHMA
Margaret Guill, M.D., Augusta

10:30-10:45 QUESTION AND DISCUSSION

10:45-11:00 COFFEE BREAK

11:00-12:00 PULMONARY TRANSPLANTATION
Janet Maurer, M.D.

12:00- 1:30 LUNCH BREAK

1:30- 2:30 PULMONARY INVOLVEMENT
Diane Stover, M.D.

2:30-3:15 PULMONARY DISABILITY EVALUATION
Murray J. Gilman, M.D.
Atlanta

3:15- 3:30 COFFEE BREAK

RESEARCH AWARDEES OF THE GEORGIA LUNG ASSOCIATION

3:30- 4:15 PULMONARY VASCULAR REACTIVITY
John Catravas, Ph.D., Augusta

4:15- 5:00 PATHOGENESIS AND EVALUATION OF SARCOIDOSIS
Gerald W. Staton, Jr., M.D., Atlanta

5:00- 5:20 QUESTIONS AND DISCUSSION

5:30- 6:30 BUSINESS MEETING
GEORGIA THORACIC SOCIETY

6:30-7:30 RECEPTION
Georgia Thoracic Society

## SATURDAY, NOVEMBER 21

9:00- 9:45 LEGAL ASPECTS OF HOME CARE
Jill D. Herron, J.D.
Sponsored by Travenol

9:45-10:45 EMERGENCY MANAGEMENT OF ASTHMA
Christopher Fanta, M.D., Boston

10:45-11:00 QUESTIONS AND DISCUSSION

11:00-11:15 COFFEE BREAK

11:15-12:15 NEWER MODALITIES OF MECHANICAL VENTILATION
M. Christine Stock, M.D., Atlanta

12:15- 1:15 UPDATE ON TUBERCULOSIS
Richard J. O'Brien, M.D., Atlanta

We gratefully acknowledge the sponsorship of guest speakers by the following companies:

Boehringer-Ingelheim — Dr. Fanta
Glaxo — Dr. Maurer
Purdue-Frederick — Dr. Staton
Smith Kline and French — Dr. Stover
Travenol — Ms. Herron

This program has also been partially funded through contributions from Merck Sharpe and Dohme and Roerig-Pfizer.

# EMERGENCY MEDICINE

## SATURDAY MORNING

## GEORGIA CHAPTER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

*Program Chairman:*
**Walter E. Limehouse, Jr., M.D.,** Atlanta
*Guest Speakers:*
**Terry L. Schmidt**
Washington, D.C. and La Jolla, CA
Saul R. Epstein
Philadelphia, PA

### SATURDAY, NOVEMBER 21

| | |
|---|---|
| 8:00-10:00 | MEDICARE REGULATIONS AFFECTING PHYSICIANS CONTRACTUAL RELATIONSHIPS BETWEEN PHYSICIANS AND HOSPITALS |
| 10:00-10:30 | COFFEE BREAK |
| 10:30-12:30 | STRATEGIES FOR MAXIMIZING REIMBURSEMENT PRACTICE PLANS |
| 12:30 | ADJOURNMENT |

# NEUROLOGY

## SATURDAY

## GEORGIA NEUROLOGICAL SOCIETY

*Program Chairman:*
**Mark A. Kozinn, M.D.,** Atlanta

The Georgia Neurological Society will hold its meeting Saturday, November 21, from 9 a.m. to 2:30 p.m. Guest speaker will be H. Richard Tyler, M.D., Professor of Neurology, Harvard Medical School. Other local faculty will complete the program.

# NEUROSURGERY

## SATURDAY AND SUNDAY MORNINGS

## GEORGIA NEUROSURGICAL SOCIETY

*Program Chairman:*
**Roy P. Baker, M.D.,** Savannah

The Society clinical session will be held on Saturday morning, November 21, with J. Mike McWhorter, M.D., Associate Professor of Neurological Surgery, Bowman Gray School of Medicine, as guest speaker. On Sunday morning the Society will hold its annual socioeconomic update.

# OBSTETRICS-GYNECOLOGY

## FRIDAY AFTERNOON

## GEORGIA OBSTETRICAL AND GYNECOLOGICAL SOCIETY

*Program Chairman:*
**Matthew O. Burrell, M.D.,** Atlanta
*Faculty:*
**Michael Campion, M.D.**
Regional Cancer Center
St. Joseph's Hospital, Atlanta
**Leo Plouffe, Jr., M.D.**
MCG, Augusta

### FRIDAY, NOVEMBER 20

| | |
|---|---|
| 1:00 P.M. | INTRODUCTION Matthew O. Burrell, M.D. |
| 1:05- 2:20 | WHAT YOU NEED TO KNOW ABOUT THE GENITAL HUMAN PAPILLOMA VIRUS EPIDEMIC Michael Campion, M.D. |
| 2:20- 2:30 | QUESTIONS AND ANSWERS |
| 2:30- 2:50 | COFFEE BREAK |
| 2:50- 4:05 | NEW APPROACHES TO ESTROGEN REPLACEMENT IN THE MENOPAUSE Leo Plouffe, Jr., M.D. |
| 4:05- 4:15 | QUESTIONS AND ANSWERS |
| 4:15 | ADJOURNMENT |

Following this program, all members of the Georgia Obstetrical and Gynecological Society are invited to the dinner meeting of the Atlanta Obstetrical-Gynecological Society. For reservations, please contact Willis Lanier, M.D., 960 Johnson Ferry Road, NE, Atlanta 30342. Phone: 404/255-3633.

# OPHTHALMOLOGY

## SATURDAY

## GEORGIA SOCIETY OF OPHTHALMOLOGY

*Program Chairman:*
**Thomas S. Rowe, M.D.,** Atlanta
*Guest Speaker:*
**Darrell E. Wolfley, M.D.**
Chairman, Department of Ophthalmology, Louisiana State University School of Medicine, New Orleans

### SATURDAY, NOVEMBER 21

9:00- 9:05 OPENING REMARKS
J. Donald Fite, M.D., President
Georgia Society of Ophthalmology

9:05- 9:15 ACUTE RETINAL NECROSIS — MANAGEMENT WITH VITRECTOMY
William S. Hagler, M.D.

9:15- 9:25 PROLIFERATIVE VITREO-RETINOPATHY WITH RETRORETINAL MEMBRANES
Shelby Wilkes, M.D.

9:25- 9:35 THE COLLABORATIVE OCULAR MELANOMA STUDY
Travis A. Meredith, M.D.

9:35- 9:45 TWINS AND RETINOBLASTOMA: SUPPORT FOR THE TWO-HIT HYPOTHESIS
Paul Sternberg, M.D.

9:45-10:00 DISCUSSION

10:00-10:20 PRE-OPERATIVE EVALUATION OF THE BLEPHAROPLASTY PATIENT
Darrell E. Wolfley, M.D.

10:20-10:50 COFFEE BREAK

10:50-11:00 ARE THERE EXTRANEURONAL SITES OF LATENCY FOR HERPES SIMPLEX VIRUS IN THE EYE?
R. Doyle Stulting, M.D.

11:00-11:10 CORNEAL COLLAGEN SHIELD
Robert H. Marmer, M.D.

11:10-11:20 POST TRAUMATIC STERILE CORNEAL ABSCESS
C. Howell Tucker, M.D.
David S. Hull, M.D.

11:20-11:30 DISCUSSION

11:30-11:40 DENDRITIFORM LESIONS OF THE CORNEA
Philip E. Newman, M.D.

11:40-11:50 EXCIMER LASER SURGERY OF THE CORNEA
George O. Waring, M.D.

11:50-12:00 DISCUSSION

12:00-12:20 UPPER AND LOWER LID BLEPHAROPLASTY
Darrell E. Wolfley, M.D.

12:20- 2:00 LUNCHEON — MEMBERS AND GUESTS
Georgia Society of Ophthalmology

2:00- 2:10 ADJUNCTIVE BROW PROCEDURE FOR UPPER LID BLEPHAROPLASTY
Clinton D. McCord, Jr., M.D.

2:10- 2:20 DIPLOPIA IN ORBITAL FLOOR BLOWOUT FRACTURES
Ted H. Wojno, M.D.

2:20- 2:30 DOCUMENTATION OF SUBTLE DYSTHYROID OPHTHALMOPATHY: CT VERSUS ORBITAL ULTRASONOGRAPHY
Robert H. Spector, M.D.

2:30- 2:40 PNEUMATIC RETINOPEXY
William H. Jarrett, M.D.

2:40- 2:50 DISCUSSION

2:50- 3:00 OCCULT METALLIC INTRAOCULAR FOREIGN BODY
Scott I. Lampert, M.D.

3:00- 3:10 TREATMENT OF CYCLOTORSION ASSOCIATED WITH SUPERIOR OBLIQUE PALSIES
Zane F. Pollard, M.D.

3:10- 3:20 DISCUSSION

3:20- 3:40 COFFEE BREAK

3:40- 3:50 GONIOSYNECHIALYSIS: A NEW SURGICAL APPROACH IN THE MANAGEMENT OF NEOVASCULAR GLAUCOMA
M. Angela Vela, M.D.

3:50- 4:00 ACUTE ANGLE CLOSURE GLAUCOMA — MEDICAL AND LASER TREATMENT
Thomas F. Harbin, Jr., M.D.

4:00- 4:10 ALTERATIONS IN CORNEAL TOPOGRAPHY FOLLOWING RETINAL DETACHMENT SURGERY
Ray M. Balyeat, M.D.

4:10- 4:20 ENDOLASER TREATMENT OF NEOVASCULAR GLAUCOMA
Edwin H. Donnelly, M.D.

4:20- 4:30 DISCUSSION

4:30- 5:00 BUSINESS MEETING
Georgia Society of Ophthalmology

# ORTHOPAEDIC SURGERY

## SUNDAY

## GEORGIA ORTHOPAEDIC SOCIETY

*Program Chairman:*
**William C. Collins, M.D.** Atlanta

The Society will hold a meeting on Sunday morning, November 22, with didactic presentations. After lunch, a special "hands-on" learning session will be featured.

# OTOLARYNGOLOGY HEAD AND NECK SURGERY

## FRIDAY MORNING

## GEORGIA SOCIETY OF OTOLARYNGOLOGY/HEAD AND NECK SURGERY

*Program Chairmen:*
**Albert E. Clairmont, M.D.,** Atlanta
**William E. Silver, M.D.,** Atlanta
*Guest Speaker:*
**Darrell E. Wolfley, M.D.**
Chairman, Department of Ophthalmology
Louisiana State University School of Medicine
New Orleans

### FRIDAY, NOVEMBER 20

| | |
|---|---|
| 9:00- 0:05 | WELCOME AND INTRODUCTION<br>Albert A. Clairmont, M.D. |
| 9:05- 9:15 | NON-CAUCASIAN RHINOPLASTY<br>William E. Silver, M.D. |
| 9:15- 9:20 | QUESTIONS AND ANSWERS |
| 9:20- 9:50 | BLEPHAROPLASTY<br>Darrell E. Wolfley, M.D. |
| 9:50-10:00 | QUESTIONS AND ANSWERS |
| 10:00-10:20 | THE DIFFICULT NOSE<br>Ramon S. Franco, M.D. |
| 10:20-10:25 | QUESTIONS AND ANSWERS |
| 10:25-10:40 | COFFEE BREAK |
| 10:40-11:00 | DIFFICULT DIAGNOSES IN THE VERTIGINOUS PATIENT<br>Ronald Steenerson, M.D. |
| 11:00-11:10 | QUESTIONS AND ANSWERS |
| 11:10-11:30 | ENDOSCOPIC SINUS SURGERY: INDICATIONS, ADVANTAGES AND COMPLICATIONS<br>William J. Grist, M.D. |
| 11:30-11:35 | QUESTIONS AND ANSWERS |
| 11:35-11:55 | MANAGEMENT DILEMMAS IN OTITIS MEDIA WITH EFFUSION<br>Benjamin White, M.D.<br>Atlanta |
| 11:55-12:00 | QUESTIONS AND ANSWERS |
| 12:00 | ADJOURN |

# PATHOLOGY

## SATURDAY AND SUNDAY

## GEORGIA ASSOCIATION OF PATHOLOGISTS ATLANTA SOCIETY OF PATHOLOGISTS

### SATURDAY, NOVEMBER 21

*Program Chairman:*
**William R. Beach, M.D.,** Atlanta
President, Georgia Association of Pathologists
*Guest Speakers:*
**Lowell Foster, Ph.D.**
International Clinical Laboratories
Nashville, TN
Dennis Padget
President, Padget & Associates
Louisville, KY

| | |
|---|---|
| 9:00-10:00 | BRONCHOALVEOLAR LAVAGE — WHAT THE PULMONOLOGIST WANTS TO KNOW<br>Barbara A. Slade, M.D.<br>Atlanta |
| 10:00-10:15 | COFFEE BREAK |
| 10:15-11:00 | TUMOR CHEMOSENSITIVITY — THE NEXT STEP<br>Lowell Foster, Ph.D. |
| 11:00-12:00 | CLINICAL CONSULTATIONS — MCG EXPERIENCE<br>Robert Baisden, M.D.<br>Medical College of Georgia<br>Augusta |
| Noon- 1:30 | LUNCH BREAK |
| 1:30- 2:00 | FLOW CYTOMETRY IN TUMOR DIAGNOSIS<br>Lowell Foster, Ph.D. |
| 2:00- 3:00 | CPT CODES — A SOURCE OF INCOME LOSS<br>Dennis Padget |
| 3:00- 3:15 | COFFEE BREAK |
| 3:15- 4:00 | CPT CODES (cont'd)<br>Dennis Padget |

4:00- 5:00 LEGISLATIVE UPDATE AND BUSINESS MEETING
Georgia Association of Pathologists

5:00- 6:30 RECEPTION — MEMBERS AND GUESTS
Georgia Association of Pathologists

We gratefully acknowledge the support of International Clinical Laboratories in sponsoring Dr. Foster's presentations.

### SUNDAY, NOVEMBER 22

*Program Chairman:*
**Barbara A. Slade, M.D.**
President, Atlanta Society of Pathologists
*Guest Speaker:*
**Anna-Luise A. Katzenstein, M.D.**
Professor of Pathology
University of Alabama School of Medicine
Birmingham

9:00- 1:00 NON-NEOPLASTIC PULMONARY PATHOLOGY
Anna-Luise A. Katzenstein, M.D.

A coffee break is scheduled during Dr. Katzenstein's presentation, 10:30-11:00 a.m.

Microscopic slide study sets, including clinical protocols, have been prepared for the cases which Dr. Katzenstein will present. Sets are available for $40. Requests should be submitted to:

Barbara A. Slade, M.D.
Clinical Laboratory
Grady Memorial Hospital
80 Butler Street, S.E.
Atlanta, Georgia 30335
PH: (404) 589-4800

## PLASTIC SURGERY

### SATURDAY MORNING

### GEORGIA SOCIETY OF PLASTIC SURGEONS

*Program Chairman:*
**W. Jefferson Pendergrast, M.D.,** Atlanta
*Faculty:*
**Norman M. Cole, M.D.**
Louisville, KY

### SATURDAY, NOVEMBER 21

9:00- 1:00 RISK MANAGEMENT AND LOSS PREVENTION TECHNIQUES
Norman M. Cole, M.D.

Dr. Cole's presentation will feature medical/legal essentials for the medical record, consultation, informed consent and testimony in Plastic Surgery.

A coffee break is scheduled for 11:00-11:15 a.m.

1:00- 3:00 LUNCHEON AND BUSINESS MEETING
Georgia Society of Plastic Surgeons

Reservations must be made for the Society luncheon by noon, November 18, by contacting James R. Russell, M.D., Treasurer, 3250 Howell Mill Road, N.W., Atlanta 30308. PH: (404) 351-9868.

## PSYCHIATRY

### FRIDAY

### GEORGIA PSYCHIATRIC ASSOCIATION

### TREATMENT STRATEGIES FOR REFRACTORY PSYCHIATRIC DISORDERS

*Program Chairman:*
**Alan Stoudemire, M.D.,** Atlanta
*Faculty:*
**Richard Borison, M.D.**
Professor of Psychiatry
Medical College of Georgia
Augusta
**Bill Nelson, M.D.**
Professor and Chairman
Department of Psychiatry
Mercer University School of Medicine
Macon
**Morton F. Rieser, M.D.**
Albert E. Kent Professor of Psychiatry
Yale University School of Medicine
Former President, American Psychoanalytic Association
New Haven, CT
**Alan Schatzberg, M.D.**
Associate Professor of Psychiatry
Harvard Medical School
Co-Director, Affective Disorders Research Program, McLean Hospital
Boston

**Alan Stoudemire, M.D.**
Associate Professor of Psychiatry
Director, Medical-Psychiatry Unit
Emory University School of Medicine

### FRIDAY, NOVEMBER 20

8:30- 9:15 REGISTRATION AND CONTINENTAL BREAKFAST
9:15- 9:30 WELCOME
Alan Stoudemire, M.D.
9:30-10:30 TREATMENT OF REFRACTORY DEPRESSION IN THE ELDERLY
Alan Stoudemire, M.D.
10:30-11:30 CLOZAPINE: A NEW ANTIPSYCHOTIC FOR REFRACTORY SCHIZOPHRENIA
Richard Borison, M.D.
11:30- 1:00 BUFFET LUNCHEON
1:00- 2:00 NEW PSYCHOPHARMACOLOGIC TREATMENT STRATEGIES IN ACUTE AND REFRACTORY DEPRESSION
Alan Schatzberg, M.D.
2:00- 3:00 THE INTEGRATION OF PSYCHODYNAMICS AND NEUROBIOLOGY IN THEORY AND CLINICAL PRACTICE
Morton F. Rieser, M.D.
3:00- 3:45 CASE PRESENTATION
Bill Nelson, M.D.
DISCUSSION
Dr. Schatzberg and Dr. Rieser
3:45 ADJOURNMENT

We wish to thank Mead-Johnson Pharmaceuticals, Merrell-Dow Pharmaceuticals, Sandoz Pharmaceuticals, and the Upjohn Company for their generous support of this program.

## SURGERY

### FRIDAY AND SATURDAY

## GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS

### SESAP V REVIEW COURSE

*Program Chairman:*
**Robert D. Gongaware, M.D.,** Savannah

### FRIDAY, NOVEMBER 20

8:00 WELCOME AND ANNOUNCEMENTS

SESSION 1 —
Charles Ferguson, M.D., Presiding

8:05- 8:30 FLUIDS AND ELECTROLYTES
William J. Millikin, Jr., M.D.
8:35- 9:00 SURGICAL INFECTION
John R. Galloway, M.D.
9:05- 9:30 NUTRITION
Joseph D. Ansley, M.D.
9:30- 9:55 DISCUSSION
9:55-10:15 COFFEE BREAK

SESSION II
Charles Ferguson, M.D., Presiding

10:15-10:40 HEMATOLOGY
Hunter Jennings, M.D.
10:45-11:10 TRANSPLANT AND IMMUNOLOGY
John D. Whelchel, M.D.
11:15-11:40 INTENSIVE CARE
J. Michael Henderson, M.D.
11:45-12:10 DISCUSSION
12:15- 1:30 LUNCH BREAK

SESSION III

1:30- 1:55 BILIARY TRACT AND PANCREAS
Edward L. Bradley, III, M.D.
2:00- 2:25 HEAD AND NECK
John J. Coleman, III, M.D.
2:30- 2:55 BREAST DISEASES
R. Waldo Powell, M.D.
3:00- 3:25 DISCUSSION
3:30- 4:00 COFFEE BREAK

SESSION IV

4:00- 4:25 HAND SURGERY
Foad Nahai, M.D.
4:30- 4:55 CARDIAC SURGERY
Robert A. Guyton, M.D.
5:00- 5:25 VASCULAR SURGERY I
Mark T. Stewart, M.D.
5:30- 6:00 DISCUSSION

### SATURDAY, NOVEMBER 21

SESSION V
Robert D. Gongaware, M.D., Presiding

8:00- 8:25 PEDIATRIC SURGERY
Robert D. Gongaware, M.D.
8:30- 8:55 ONCOLOGY
James Evans, M.D.
9:00- 9:25 TRAUMA
Carl Boyd, M.D.
9:30- 9:55 DISCUSSION
10:00-10:30 COFFEE BREAK

SESSION VI
Robert Nesbit, M.D., Presiding

10:30-10:55 SURGICAL ENDOCRINOLOGY
Arlie R. Mansberger, M.D.
11:00-11:25 RESPIRATORY CARE & ANESTHESIA
Daniel S. Rowe, M.D.
11:30-11:55 BURNS
Richard C. Treat, M.D.
12:00-12:25 DISCUSSION
12:30- 1:45 LUNCH BREAK

SESSION VII
Robert Nesbit, M.D., Presiding

1:45- 2:10 COLON
Talmadge A. Bowden, Jr., M.D.
2:15- 2:40 LIVER
Richard C. Treat, M.D.
2:45- 3:10 STOMACH & SMALL BOWEL
Talmadge A. Bowden, Jr., M.D.
3:15- 3:40 DISCUSSION
3:40- 4:15 COFFEE BREAK

SESSION VIII
Robert Nesbit, M.D., Presiding

4:15- 4:40 NON-CARDIAC THORACIC
Ganesh Pai, M.D.
4;45- 5:10 VASCULAR II
Robert Nesbit, M.D.
5:15- 5:40 ESOPHAGUS
Ganesh Pai, M.D.
5:45- 6:10 DISCUSSION


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Atlanta, Ga. 30308

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**Contraindications:** Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum $K^+$ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict $K^+$ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

**Precautions:** The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

**Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.**

BRS-DZ:L42

# In Hypertension*... When You Need to Conserve $K^+$

## Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum $K^+$ and BUN should be checked periodically (see Warnings and Precautions).

Potassium-Sparing

**DYAZIDE®**

**25 mg** Hydrochlorothiazide/**50 mg** Triamterene/SKF

**Over 20 Years of Confidence**

The unique red and white Dyazide® capsule: Your assurance of SK&F quality.

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# There's never been a better time for her.

# nd PREMARIN®

## Proven benefits beyond relief of vasomotor symptoms

## No other estrogen proven effective for osteoporosis

Only conjugated estrogens tablets have established efficacy in both osteoporosis[1] and vasomotor symptoms* at 0.625 mg/day. No other estrogen, oral or transdermal, has established clinical evidence or minimum effective dose in both indications.

## No estrogen proven safer

PREMARIN is the most extensively tested estrogen, with an unsurpassed record of long-term safety.
And clinical evidence shows a significantly reduced risk of endometrial hyperplasia when cycled with a progestin.[2]

# PREMARIN®
(conjugated estrogens tablets)

## Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

# For moderate-to-severe vasomotor symptoms and for osteoporosis

# PREMARIN®
(conjugated estrogens tablets)

0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

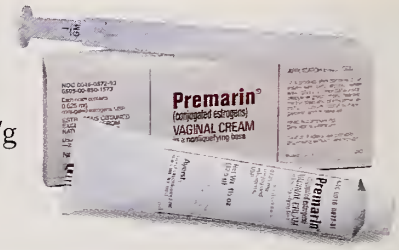
The appearance of these tablets is a trademark of Ayerst Laboratories.

# For atrophic vaginitis

# PREMARIN®
(conjugated estrogens)

Vaginal Cream

0.625 mg/g




BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

**PREMARIN® Brand of conjugated estrogens tablets, USP**
**PREMARIN® Brand of conjugated estrogens Vaginal Cream, in a nonliquefying base**

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA.
Three independent, case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses.
2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.
The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimated a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

**DESCRIPTION:** PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

**INDICATIONS AND USAGE:** PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

**Concomitant Progestin Use:** The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important, product labeling should be reviewed to minimize possible adverse effects.

**CONTRAINDICATIONS:** Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (see Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

**WARNINGS:** Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning). However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement, it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

**PRECAUTIONS:** Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia or in young patients in whom bone growth is not yet complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.
b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.
c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, $T_4$ by column, or $T_4$ by radioimmunoassay. Free $T_3$ resin uptake is decreased, reflecting the elevated TBG; free $T_4$ concentration is unaltered.
d. Impaired glucose tolerance.
e. Decreased pregnanediol excretion.
f. Reduced response to metyrapone test.
g. Reduced serum folate concentration.
h. Increased serum triglyceride and phospholipid concentration.

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

**ADVERSE REACTIONS:** The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption, loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance, aggravation of porphyria; edema; changes in libido.

**ACUTE OVERDOSAGE:** May cause nausea, and withdrawal bleeding may occur in females.

**DOSAGE AND ADMINISTRATION:**

**PREMARIN® Brand of conjugated estrogens tablets, USP**

1. *Given cyclically for short-term use only.* For treatment of moderate-to-severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.
2. *Given cyclically:* Osteoporosis. Female castration. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off). Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

**PREMARIN® Brand of conjugated estrogens Vaginal Cream**

*Given cyclically for short-term use only.* For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three- to six-month intervals.

Usual dosage range: 2 g to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

**References:**


1. Lindsay R, Hart DM, Clark DM: The minimum effective dose of estrogen for prevention of postmenopausal bone loss. *Obstet Gynecol* 1984;63:759-763. 2. Studd JWW, Thom MH, Paterson MEL, et al: The prevention and treatment of endometrial pathology in postmenopausal women receiving exogenous estrogens, in Pasetto N, Paoletti R, Ambrus JL (eds): *The Menopause and Postmenopause*. Lancaster, England, MTP Press Ltd, 1980, chap 13.



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New York, NY 10017

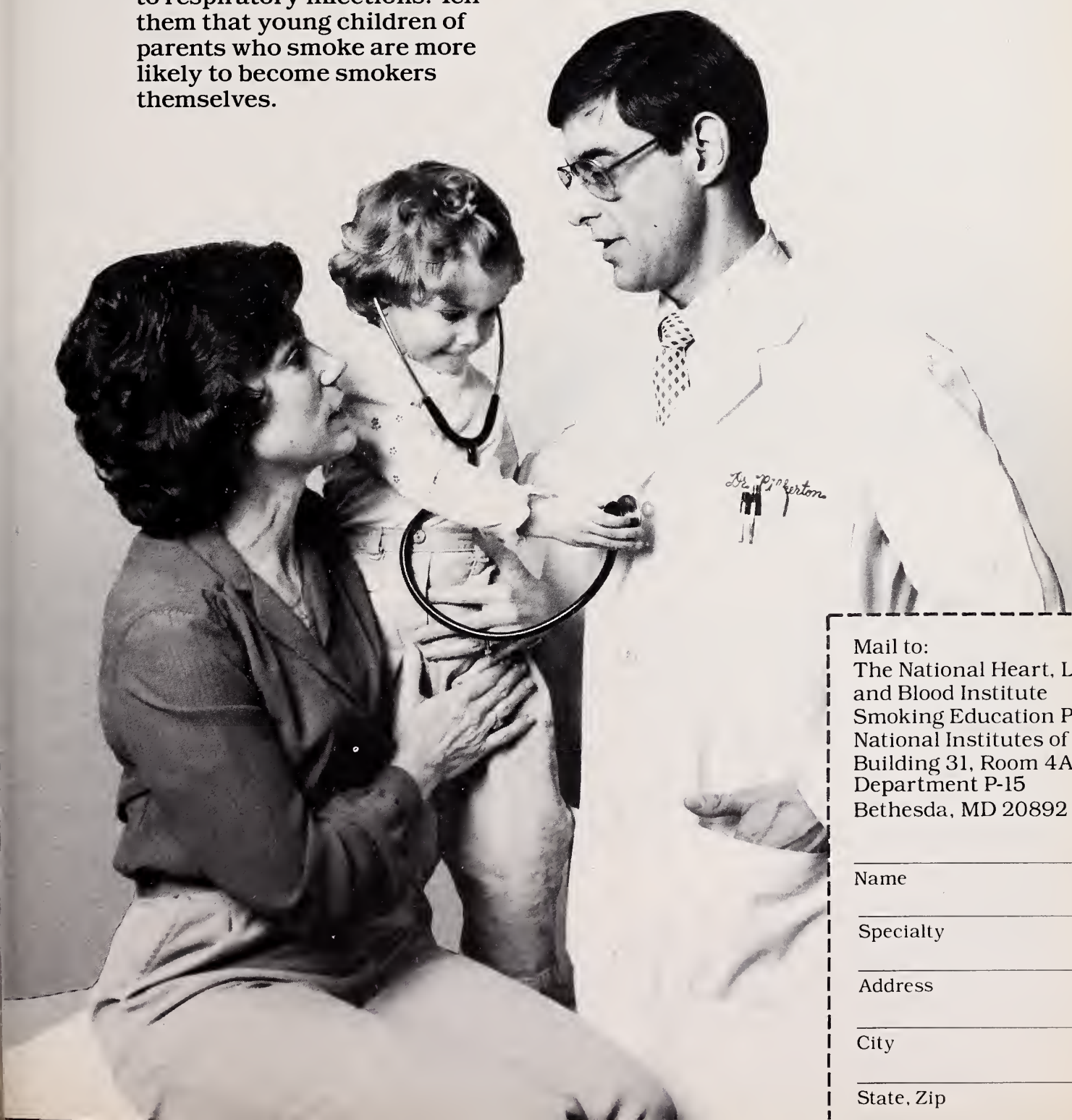
# A Clinical Opportunity for Smoking Intervention

You can play a special role in reaching smokers. Encouraging parents not to smoke can improve the health of the entire family.

Take a few minutes to explain that children of parents who smoke are often more prone to respiratory infections. Tell them that young children of parents who smoke are more likely to become smokers themselves.

The minutes you spend can make a difference now, and in the years ahead.

For a free copy of *Clinical Opportunities for Smoking Intervention: A Guide for the Busy Physician*, complete the form below.



Mail to:
The National Heart, Lung, and Blood Institute
Smoking Education Program
National Institutes of Health
Building 31, Room 4A 18
Department P-15
Bethesda, MD 20892

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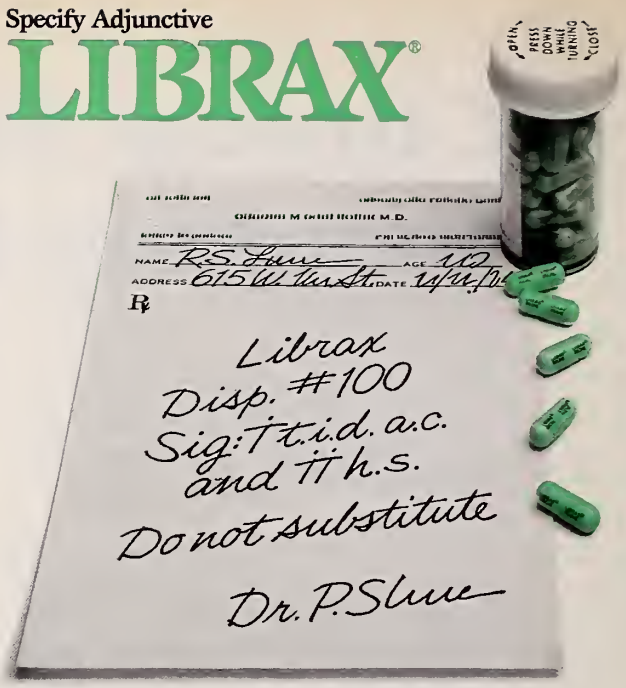
Specify Adjunctive

# LIBRAX®




Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

*Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE® Roche Products Inc.
Manati, Puerto Rico 00701

P.I. 0186

To insist on the brand, be sure to sign the "Dispense as Written" line on your prescription.

When brain and bowel conflict...

# It's time for the Peacemaker.

**In irritable bowel syndrome*** anxiety can aggravate intestinal symptoms, which may further intensify anxiety — a distressing cycle of brain/bowel conflict. Librax intervenes with two well-known compounds. The Librium® (chlordiazepoxide HCl/Roche) component safely relieves anxiety. And Quarzan® (clidinium bromide/Roche) provides antisecretory and antispasmodic action to relieve discomfort associated with intestinal hypermotility.

Dual action — for peace between brain and bowel. Because of possible CNS effects, caution patients about engaging in activities requiring complete mental alertness. Specify Adjunctive

# LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide

*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of peptic ulcer and the irritable bowel syndrome.

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# "High Quadriplegia– The Ultimate Challenge"

Plan to attend:

***A two-day symposium at Colony Square Atlanta***

***April 7-8, 1988***

***Registration: $225***

Symposium
Co-Chairmen

David F. Apple, Jr., M.D.
Medical Director

Donald P. Leslie, M.D.
Medical Director
High Quadriplegia Program

A medical symposium addressing the acute and rehabilitative care of the C-1 through C-4 high quadriplegic. Hosted by Shepherd Spinal Center in Atlanta, now the nation's largest dedicated spinal cord injury hospital. Issues to be investigated include: medical, psychosocial and high tech approaches to care and rehabilitation. Special emphasis on ventilator weaning, the interdisciplinary care approach, phrenic nerve pacer implants and community reintegration.

## *Symposium Preview:*

### *High Quadriplegics: They Can Go Home Again*

With high quadriplegics surviving at unprecedented rates, quality of life issues and discharge planning are of paramount importance from the first day of admission to the specialty setting. The philosophy of treatment at SSC will be covered, including the referring physician's role in long-term medical management.

### *Medical Overview: Care of the High Quadriplegic*

The potential for complications such as deep vein thrombosis, stress ulceration, decubitus, pneumonia, urinary tract infections and sepsis poses a serious threat to high quadriplegic patients. Prevention strategies, the benefits of early mobilization of ventilator dependent patients and medical management of complications are covered.

### *Ventilator Weaning*

All high quadriplegics at Shepherd Spinal Center are evaluated to determine their candidacy for phrenic nerve pacer implants and their potential for weaning from mechanical ventilation. The pulmonary evaluation studies performed at SSC and protocols for weaning are included.

## *Panel and Concurrent Session Topics:*

- Pulmonary Issues
- Social Work: Discharge Planning, Peer Support, Sexuality
- The Therapeutic Value of Sensory Experience
- The Biofeedback Program at SSC
- Ventilator Home Care
- Focus On: Phrenic Pacer Implantation
- Departmental Presentations by O.T., P.T., Recreation Therapy, Social Work Respiratory Care, Education, Nutritionists
- Emphasis on specialized equipment

### *For Physicians Only:*

Grand Rounds at Shepherd Spinal Center

REGISTRATION IS LIMITED. Reserve your space today, by sending a check for $225, payable to Shepherd Spinal Center, to: Lesley M. Hudson, Symposium Registrar, Shepherd Spinal Center, 2020 Peachtree Road, N.W., Atlanta, GA 30309. Confirmations of early registrations and a symposium information packet will be mailed in October.

***High Quadriplegia– The Ultimate Challenge***

Name_____

Specialty_____

Address_____

City_____ State_____ Zip_____

Check one: ☐ Check enclosed. Reserve my space now. ☐ Please send a complete information packet.

# Case Study: Larry McAfee
# Diagnosis: C-1 Complete
# Prognosis: Promising

*Contact the Admissions Office for routine information. A physician is on 24-hour call to assist in emergency arrangements.*

hen 28 year-old Larry McAfee s brought to Shepherd Spinal nter as a result of a motor-le accident in late 1985, he s classified as a C-1 complete nal cord injury. He was suf-ing from severe burns on his ht ankle, massive atelectasis, eumothorax and pneumonia. alyzed instantly at the first vical vertebrae below the in stem, he required mechan-l ventilation for breathing.

The road to a meaningful quality of life has been a long one for Larry, requiring intensive medical care, rehabilitation, counseling–and Larry's own unsinkable spirit.

We couldn't promise Larry miracles, but we could promise him the care of the largest rehabilitation hospital in the nation specializing in paralyzing spinal cord disorders, Shepherd Spinal Center in Atlanta. With the help of various adaptive devices and skilled attendants, it is possible for Larry to live independently in an apartment since his discharge from Shepherd. He now actively pursues his goal of a career as a computer programming consultant.

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# ADVERTISING INDEX


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Atlanta Magnetic Imaging ..... 712

Ayerst Laboratories ..... 696A-D, 720B-D

Baldwin County Hospital ..... 665

Citizens and Southern Trust Company ..... 694

Classified Ads ..... 727

Clinical Opportunity for Smoking Intervention ..... 721

CNA Insurance ..... 682

CPC Parkwood ..... 705

Diversified Auto Leasing ..... 693

Family Practice Recertification ..... 696

Financial Seminars ..... 702

Health Quip, Inc. ..... 722

Lilly, Eli & Company ..... 688B

MAG Mutual Insurance Company ..... 664

Medic Computer ..... 676

Midtown Hospital ..... 720

M$NY Credit Corporation ..... 688

Profitable Practices ..... 680

Roche Laboratories ..... 680A-D, 722-723, 729-730

Shephard Spinal Center ..... 724-725

Smith Kline & French Laboratories ..... 720A

Upjohn Company ..... 688A

U.S. Army ..... 706

Weight Watchers of Greater Atlanta ..... 722

Wesley Woods Geriatric Teaching and Research Hospital ..... 666

Woodridge Hospital ..... 712


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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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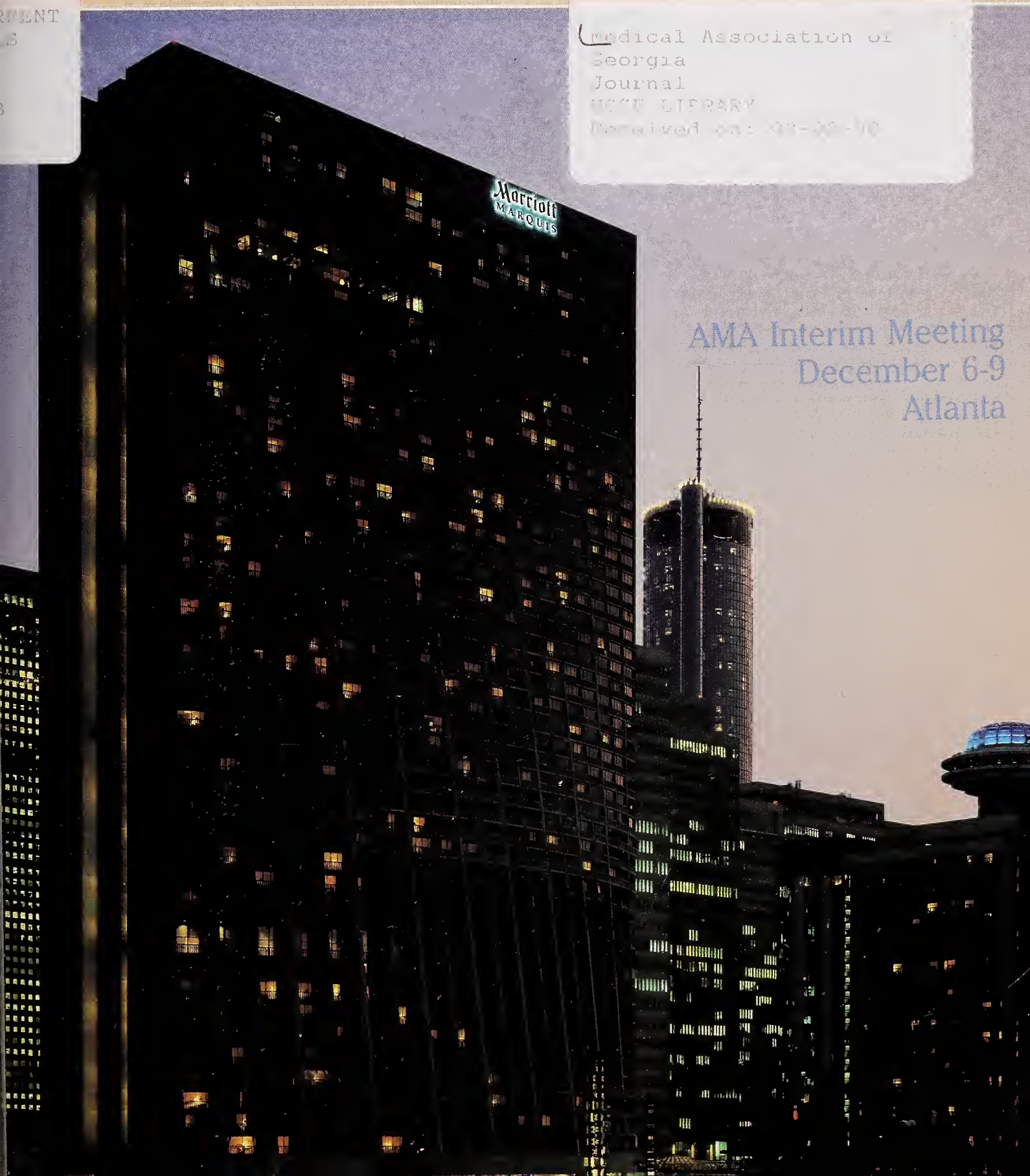


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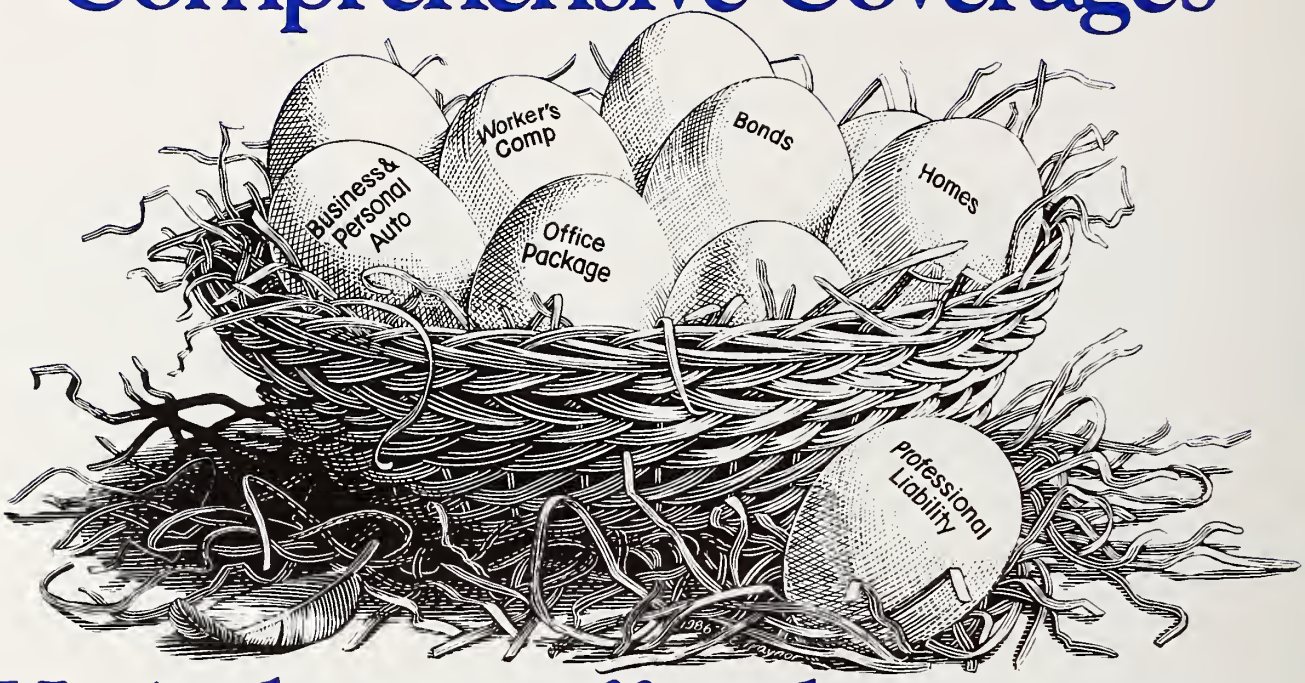


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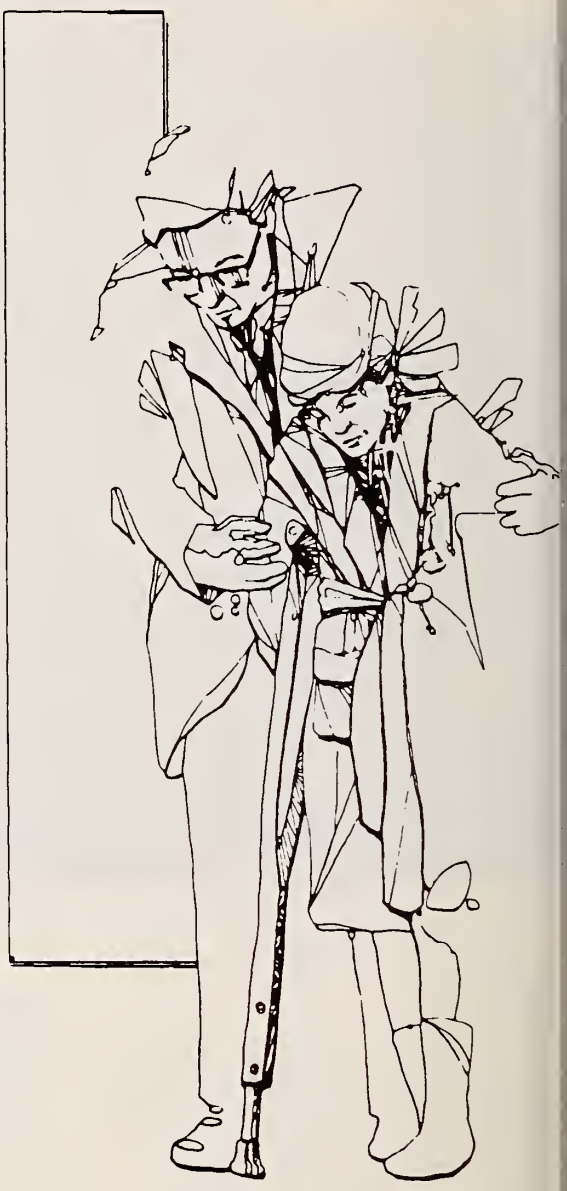

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# CONTENTS

**VOLUME 76, NUMBER 11**

## FEATURES

A COMPARISON OF ALCOHOLICS AND COCAINE ADDICTS ONE YEAR FOLLOWING INPATIENT TREATMENT 751
Howard M. Strickler, M.D., Carolyn A. Martin, Ph.D.
Raymond H. Sowell, Jr., M.D., Al J. Mooney, III, M.D.

AMA COMES TO THE PEACH STATE 758

ORGAN AND TISSUE DONATION, 1987 766
P. A. Bowen, M.D., M.A. House, R.N., M.S.N.,
A. L. Humphries, M.D., A. R. Mansberger, M.D.

IDIOPATHIC THROMBOCYTOPENIC PURPURA IN CHILDHOOD: A CURRENT PERSPECTIVE 771
Hernan Sabio, M.D., Virgil C. McKie, M.D.,
P. Charlton Davis, Jr., M.D.

WILLIAM L. BARTON, M.D., A PIONEER IN OTOLARYNGOLOGY 775
Miguel A. Faria, Jr., M.D.

METOCLOPRAMIDE-INDUCED GALACTORRHEA 777
James O. Day, M.D., F.A.C.P.

## EDITORIALS

THE STOMACH BUBBLE: A QUICK FIX OR ANOTHER FAD? 738
William M. Headley, M.D.

THE AMA IS COMING! 739
C. Emory Bohler, M.D.

## HEART

CONGENITAL HYPOPLASIA OF THE LEFT ANTERIOR DESCENDING CORONARY ARTERY SIMULATING MYOCARDIAL ISCHEMIA 784
Syed H. Shirazi, M.D., Byron R. Williams, Jr., M.D.

## CANCER

MAMMOGRAPHY IN ATLANTA 788
Wong-Ho Chow, Ph.D., Jonathan M. Liff, Ph.D.,
Raymond S. Greenberg, M.D., Ph.D.

## DEPARTMENTS

NEWS CAPSULES 736
CALENDAR 747
EDITOR'S CORNER 740
LETTERS TO THE EDITOR 742
PRESIDENT'S PAGE 743
ASSOCIATION NEWS 744
HOSPITAL NEWS 748
INDEX TO ADVERTISING/MANUSCRIPT INFORMATION 782

## COVER

For the first time in this century (and the third time ever), the AMA will hold its interim meeting in Atlanta at the Marriott Marquis, December 6-9.
Photo courtesy of John Portman and Associates, Architects, Atlanta.

## Physician's Art on Exhibit at Highland Gallery

COINCIDING WITH THE MEETING of the American Society of Plastic and Reconstructive Surgeons in Atlanta in November will be an exhibit of paintings by Dr. Richard Hagerty at Highland Gallery from November 7 through December 9, 1987.

The plastic surgeon from Charleston has the distinction of being one of the few physicians known to have a dual career as an artist. The self-taught watercolor painter lived in Atlanta from 1978 to 1984, where he began to paint seriously during his internship and residencies at Grady Memorial Hospital, working at his easel from fifteen minutes to two hours each day. At the end of a year he had his first gallery showing — which was a sellout.

Other gallery and museum showings in Georgia and South Carolina followed, and a commission to paint the cover poster for Piccolo Spoletto at the Spoletto Festival in Charleston in 1984, about the time he returned to Charleston to enter practice with his father, Robert Hagerty.

The sure hand and eye of the surgeon are evident in the artist's expert draftsmanship and use of color in the delightful allegorical paintings.

* * *

*Expedients are for the hour; principles for the ages.*
HENRY WARD BEECHER

## Georgia Vital Records Form To Be Revised

THE NATIONAL CENTER for Health Statistics (NCHS) recently released copies of model birth, death, spontaneous abortion and induced abortion records to state vital records registrars. The model certificates had been developed and recommended by a national committee of state vital records registrars and health statisticians. The committee members reviewed expert testimony from various medical and non-medical professional groups familiar with vital records. Other interested groups or individuals from across the nation were also invited to participate in discussions about the content of these records. The purpose of recommending changes to the various vital records was to develop documents which could be utilized for the next 8-10 years to meet state and national legal and statistical needs.

The release of these certificates marks the beginning for state review and implementation of revised vital records. Each state will be reviewing its own legal and health statistics needs using the model NCHS vital records as a basis. The state of Georgia currently uses modified versions of 1978 recommended NCHS vital records and is scheduled to use the 1986 recommended versions.

There are several reasons to continue to employ the model NCHS vital records in Georgia. First, the state receives considerable state and federal funding for the provision of various health services. Evaluations using summary statistics taken from vital records are important to test the efficacy of these intervention strategies, for example WIC and family planning. Second, the continuity of vital records mortality and natality data is essential when examining disease patterns and multi-year trends. Third, the comparison of health statistics between communities, counties, states and nations depends upon the use of vital records data. For example, in order to utilize state vital statistics data, NCHS contracts with all states, including Georgia, to provide a comparable core set of information which is used in national health-related investigations. These data are taken from birth, death, and spontaneous abortion records.

Changes under consideration for Georgia vital records primarily affect live birth and spontaneous abortion records. New questions on these records are concerned with mother's and father's occupation, clinical estimate of gestation at birth, infant transfer, alcohol and smoking during pregnancy and, more "check-off" choices in the pregnancy history section. The purpose of adding these questions is to provide a more complete measure of pregnancy history, risk factors and medical problems related to childbirth. Induced abortion and death certificates will remain the same as those records currently in use.

The schedule for the review and implementation of the revised

orgia live birth and spontaneous ortion records is:

Prepare drafts of birth and spontaneous records mid-1987;
Review the drafts with Georgia medical and non-medical groups familiar with vital records and prepare final forms by December, 1987;
Revise vital record instruction manuel by spring, 1988;
Conduct regional training for vital records, hospital and medical record staff, and distribute manual, summer through fall 1988 and;
Begin use of new records January 1, 1989.

e successful implementation of ised live birth and spontaneous ortion certificates greatly pends upon appropriate hospital ff to be trained to complete se records accurately and in a ely manner. State and county l records staff are available for truction or explanation arding the completion of vital ords. Comments about the posed vital records revision may sent to Mr. Michael R. Lavoie, ector, Vital Records and Health tistics, Room 217H, 47 Trinity ., Atlanta, GA 30334.

## HHS Prepares Reforms For hysician Payment

URPRISED by the 11.7 percent surge in physician services to licare beneficiaries in 1987, S is preparing a host of ysician-payment reforms. HHS "totally underestimated" the increase in the volume of physician services that were responsible for nearly 60 percent of the record $6.90 Medicare Part B increase for 1988, according to a draft notice formally announcing the increase. Total Part B expenditures in 1987 were 12.1 percent higher than those projected by HHS, which stated that Part B outlays are expected to rise 13.9 percent in 1988.

## Contact With AIDS Virus Caused Worker's Infection

FEDERAL HEALTH officials last week said the direct contact with highly concentrated samples of the AIDS virus was "the most likely reason" a research laboratory worker became infected with the virus.

The HHS Sept. 4 reported the first known case of a laboratory worker who became infected with the virus while working with it. The exposure, which occurred in a non-governmental research facility, involved concentrations of the virus that exceed those to which most laboratory workers are exposed, according to the HHS report.

The worker, whose identity has not been disclosed, was involved in various procedures associated with the production of viruses. A team of safety experts investigating the incident said leakage from medical instruments and the laboratory's centrifuge could have resulted in the worker's direct contact with the highly concentrated virus. But the investigators found the "level of containment used in laboratories to be adequate provided there is strict adherence to recommended procedures," the HHS report stated.

## Surgeons, Radiologists Settle Chiropractor Suit

THE AMERICAN COLLEGE OF SURGEONS (ACS), Chicago, and the American College of Radiology (ACR), Reston, VA, settled last week with the chiropractor plaintiffs in the 11-year old *Wilk vs. the American Medical Association* (AMA) lawsuit. In a U.S. District Court ruling Aug. 27, the surgeons and radiologists, in addition to the AMA, were found guilty of conspiring to boycott the chiropractic profession.

The settlement for the surgeons, which was reached Sept. 23, requires the ACS to pay $200,000 to the Kentuckiana Children's Center, a Louisville, KY-based treatment center (operated by a doctor of chiropractic) that was cited as a victim of the conspiracy, according to George P. McAndrews, an attorney for the plaintiffs in the case. The ACR settlement, also reached last week, requires the association to pay $200,000 in plaintiffs' legal costs, McAndrews said. Neither the ACS nor the ACR would confirm or deny the settlements.

Some information in NEWS CAPSULES courtesy of *AHA News*.

# The Stomach Bubble: A Quick Fix or Another Fad?

*William M. Headley, M.D.*

THE VERY OBESE PATIENT presents a therapeutic challenge to the physician. Even after marked weight loss, most patients regain the lost weight and then some. This has resulted in hundreds of diets, diet pills, injections, jaw wiring, behavior modification, hypnosis, etc. Most of these methods do result in weight loss, but that is not the problem. Maintenance of the weight loss is seldom accomplished by any of the above methods in the morbidly or very obese patient.

Morbid obesity is defined as more than one hundred pounds over ideal weight or twice ideal weight and is associated with markedly increased morbidity and mortality from medical problems such as: diabetes, hypertension, orthopedic and other weight-related problems.

Estimates are that over 20,000 plastic devices (stomach bubbles) have been placed in the stomach of very obese patients during the last several years in an attempt to aid the patient in weight control. To date, no significant data to support the use of the balloon are available. The intended purpose of the device is to give the patient a sense of fullness. The patient therefore doesn't eat as much and probably will lose weight. Unfortunately, after about 3 months, many patients experience gastritis or deflation of the balloon. The Food and Drug Administration determined that the balloon is a relatively safe device as long as it is removed after 3 months, but makes no claims as to the effectiveness of the balloon in weight control. After insertion of the balloon, patients are given a course in behavior modification to teach them to eat slowly, chew their food well, and not eat too much.

Behavior modification has been notoriously ineffective over the years in management of the very obese patient. Most of the patients drop out of the Support Groups while those who remain usually don't average more than a 10 pound sustained weight loss. Inquiries made in this area of Georgia reveal that the patient or the insurance carrier is charged around $2500 for the initial insertion of the balloon and the behavior modification course. The balloon must be removed in 3 months. If another balloon is inserted later, the charges average around $1600.

As mentioned before, the problem is not in losing weight bu in maintaining the weight loss. Jav wiring, behavior modification, hypnosis, as well as hundreds of other methods have proven to be unsuccessful in the very obese anc morbidly obese patients. The stomach bubble has nothing to offer in the permanent management of weight loss. It is just another cruel blow to these very unfortunate obese people whc already have attempted unsuccessfully to manage their weight problem by multiple other means. Again they feel like failure: It is disturbing to see members of the medical profession doing this procedure on patients without scientific data to support its use.

I believe the only reasonable use of the stomach bubble at this time is its use in a morbidly obese patient who has such severe accompanying medical problems that it might be worthwhile inserting the balloon to produce some weight loss and thus enable the patient to be a safer surgical risk for the gastric bypass or vertical banded gastroplasty.

Dr. Headley is a general surgeon. Send reprint requests to him at 811 N. Cobb St., Milledgeville, GA 31061.

# The AMA is Coming!

C. Emory Bohler, M.D.

## Editor's Comment

*THE MEDICAL AND SURGICAL management of the morbidly ›ese patient has been a matter of rating controversy over the past veral years. Operations once nsidered "standard treatment" e now referred to as "obsolete." e insertion of a gastric balloon an effort to satiate the hunger ive of the morbidly obese patient yet another of these ongoing orts to solve this most gravating problem. The eceding comments by a surgeon acticing in a community hospital Georgia represent a personal inion concerning this particular dality. It is important to ognize that the entire field of atment of the morbidly obese tient is constantly evolving. The actitioner involved with these tients must be willing to proach the matter in a sound, entifically investigated manner h a commitment to life-long e of this patient population.*

CRU

* * *

*re is no mistake so great as that eing always right.*

SAMUEL BUTLER

THE INTERIM MEETING of the AMA will convene at the Atlanta Marriott Marquis Hotel, December 6-9, 1987. This will be an excellent opportunity for you who are AMA members to participate and to observe your House of Delegates in session.

AMA members are welcome and encouraged to register for the session. You will be allowed to debate items before Reference Committees and to enjoy the many Social Functions that take place during the session.

The Georgia Delegation will welcome you to our caucuses and breakfast meetings; we meet at 6:30 A.M. each day; if you wish to have breakfast with us please call Mike Fowler at MAG Headquarters so that we can arrange for food and seating for those who wish to attend.

The Southeastern Coalition Reception will be on Monday night December 7 and all registered AMA members are welcome, as they are at numerous State Delegation Receptions.

As a matter of historical interest, AMA has met only twice in Atlanta previously, in 1879 and 1896.

Again, we welcome you and earnestly request your attendance and participation.


WHY AMA?

The AMA has tackled the issue of cost effective quality medical care by supporting the development of health care coalitions. The Association believes the best mechanism for keeping health costs down without sacrificing quality or accessibility is through voluntary coalitions in which physicians actively participate. Working to promote high quality, affordable medical care in the United States: it's one more good reason why you should be a part of the AMA.

**To Join,**
Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA AMERICAN MEDICAL ASSOCIATION


Dr. Bohler is Chairman of MAG's Delegation to the

# *I Am Thankful For...*

*Charles R. Underwood, M.D.*

*I am thankful* for Autumn Mornings, brisk and cool and stimulating, with changing colors and changing temperatures promising another day of something new and different instead of the "sameness" of yesterday.

*I am thankful* for the "Land of the Free and Home of the Brave," where I am "free" enough to complain about the imperfections of this world of ours and, then, if "brave" enough, to do something about them.

*I am thankful* for the State of Georgia where small towns and those of greater magnitude find interested and capable physicians willing to put the ministering to human suffering ahead of personal gain.

*I am thankful* for "Uncle Jimmy" who taught me that even radiologists and those dealing with the more technologic side of medicine are at their best when they see sick people before they see and become overwhelmed with what the tests and the technology tell them; and for Hugh Spruell who as a country physician and surgeon told me, "I may not be the best neurosurgeon in Alabama, but right now I am the best neurosurgeon this young man has," and so helped me understand that we must all perform our best, although it be not that level of perfection for which we might yearn.

*I am thankful* for Jack and Jean Rogers and for Jack and Connie Menendez who, for the ephemeral ecstasy of a year as President and First Lady, have been willing to give up so much of personal time and means.

*I am thankful* for nurses who care for my patients in those hours when I am away from them, for the love and the tolerance and the understanding that they exhibit in a trying and soul testing environment, for the tolerance and understanding which they extend to me when I am out of patience.

*I am thankful* for young physicians who someday must assume this responsibility of caring for the sick, that mantle of responsibility bringing with it such satisfaction that few at the onset can envision it.

*I am thankful* for hospitals and the work place they provide for all o us, imperfect as are we all, but ever striving for improvement while asking little else from physicians than understanding and cooperation in reaching the common goal.

*I am thankful* for the PRO — at least I think I am — for it has, amidst the confusion, consternation, escalation of costs, and pure imbecility which it has engendered, nonetheless caused me to look more carefully at my habits, perhaps on rare occasions made me a better doctor, and identified a small but present group of inept physicians. I am thankful for the insight the PRO displayed in selecting a good and wise physician to be its medical director.

*I am thankful* for Organized Medicine and for those who support that endeavor by the many for the benefit of all.

*I am thankful* for Ellie as she represents the spouses of us all and their willingness through the years of schooling and training,

outbursts fueled by fatigue and disappointment over failure directed at no one but falling upon them — thankful for their willingness to tolerate and support us for they must represent God's most indestructible gift to His suffering servants.

*m among all of these thankful* for the Practice of Medicine, for She has provided
Excitement beyond my wildest dreams —
Challenges to waken the most somnolent spirit —
Rewards of acquaintances with such a variety of patients returning to me a sense of personal value and respect that all of Solomon's Gold could not have purchased.

*m thankful* for the poetry in mankind and for the thinkers among us who can remind us as did Charles Kingsley, "Thank God every morning when you get up that you have something to do which must be done, whether you like it or not. Being forced to work, and forced to do your best, will breed in you temperance, self control, diligence, strength of will, content, and a hundred other virtues which the idle never know."

* * *

## QUOTES

*Adhere to a definite, clear-cut purpose in life, and push forward painstakingly, perseveringly and conscientiously to its realization.*
B.C. Forbes

*Our main business is not to see what lies dimly at a distance, but to do what lies clearly at hand.*
Thomas Carlyle

*Do what you love. Know your own bone; gnaw at it, bury it, unearth it and gnaw it still.*
Henry David Thoreau

*One of the criteria of emotional maturity is having the ability to deal constructively with reality.*
William C. Menninger

*Change does not necessarily assure progress, but progress implacably requires change. Education is essential to change for education creates both wants and the ability to satisfy them.*
Henry Steele Commager

*The art of medicine consists of amusing the patient while nature cures the disease.*
Voltaire

*Mistake, error, is the discipline through which we advance.*
William Ellery Channing

*Intimacy is something essentially uncivilised.*
Gertrude Stein

*I conceived at least one great love in my life, of which I was always the object.*
Albert Camus

*No siren did ever so charm the ear of the listener as the listening ear has charmed the soul of the siren.*
Henry Taylor

*A business with an income at its heels furnishes always oil for its own wheels.*
William Cowper

*People who have no weaknesses are terrible; there is no way of taking advantage of them.*
Anatole France

*Treading on others adds nothing to our stature.*
Arnold Glasow

## An Argument Against Secrecy And AIDS

Dear Editor:

LONG BEFORE the days of calculators, the Massachusetts Legislature mandated that Pi equal 3.00 to simplify calculating for school children and craftsmen. This is about what the medical profession and public officials are doing when they advocate secrecy, civil rights, and rights of privacy (and only) for AIDS victims. Competence and compassion are necessary in the treatment of AIDS, just as we have for diabetes, cancer, syphilis, and Hansons disease. Secrecy, however, prevents mobilization of the resources necessary to stop the spread of this devastating epidemic and hides from the public the consequences of the disease. This community has many infected with HTLV III, and there have been several deaths which have been kept so secret that they do not impact on those who may contemplate risky behavior. Such secrecy also endangers those in close contact with AIDS patients, especially health care workers.

The easy thing to do is espouse education, but education has had, at best, minimal effect on drug abuse and alcoholism, modest affect on smoking, and little effect on the spread of AIDS. The hospitals in New York and San Francisco are already overwhelmed, and the epidemic is just beginning. Georgia is totally unprepared: there are no nursing homes, and public health is paralyzed by lack of information. The medical establishment and politicians will probably continue to fiddle while the epidemic explodes. We will have no one but ourselves to blame when the cost of this epidemic, both in money and lives, results in political reaction probably resulting in socialized medicine.

Sincerely,
*Olav H. Alvig, M.D.*
*Diagnostic Radiology, Cumming*

## Plaudits

Dear Editor:

CONGRATULATIONS on each of the issues of *JMAG* since your assuming the editor's position. Your editorials have been excellent — and so well written. We just assume that only the "thinking doctors" as opposed to the "cutters" have this talent and ability. You have proved them all wrong.

The most recent issue on "Hospitals" was extremely good. This should be required reading for all of us. I learned much and gained a somewhat new perspective. Our tendencies to "knee jerk" responses when the new and difficult come our way can only be modified by better understanding.

Again, congratulations and keep up the good work.

Sincerely yours,
*A. Cullen Richardson, M.D.*
*Obstetrics/Gynecology,*
*Atlanta*

## Helping the Healthy Elderly

Dear Editor,

In the MAG *Journal* of September, 1987, you have articles about caring for the elderly. You mention hospitalization, a nursing home etc. for the handicapped elderly. How about the ambulatory elderly like us who look mainly for preventive care with minimal medical problems? I will soon be 82 years old, and Mrs. Gall and I will celebrate our 52nd wedding anniversary in November. All we seek is a retirement home providing complete care at a monthly fee. The idea is to relieve us of household chores and outside maintenance. We live in a large home in Cairo, enough for more than the two of us. Relived of household chores, we could go as we please, transportation being provided or a small auto. We could participate in social activities with the other occupants. In other words, a life of ease, not boredom. This reduces stress and can prolong a useful existence without major disabilities. Why don't you concentrate on our level of elderly people and give it some publicity?

Sincerely,
*Henry Gall, M.D.*
*Pediatrics, Retired*
*Cairo*

We're Fighting For Your Life.
American Heart Association

## The benefit of antianginal protection plus safety...

# CARDIZEM®: A FULLER LIFE

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- **A remarkable safety profile**[1-6]
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†See Warnings and Precautions.

Please see brief summary of prescribing information on the next page.

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Rx

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## Usual maintenance dosage range: 180-360 mg/day

**Brief Summary**
Professional Use Information

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**CONTRAINDICATIONS**

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

**WARNINGS**

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

**PRECAUTIONS**

**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

**Drug Interaction.** Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

**Pediatric Use.** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS**

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

| | |
|---|---|
| Cardiovascular: | Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope. |
| Nervous System: | Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor. |
| Gastrointestinal: | Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase. |
| Dermatologic: | Petechiae, pruritus, photosensitivity, urticaria. |
| Other: | Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties. |

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 9/86

See complete Professional Use Information before prescribing.


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# *Healthy Lifestyles: Involving Patients in Preventive Health Care*

*Jack F. Menendez, M.D.*

ONE OF THE BIGGEST problems discussed in medical circles today is the rising cost of medical care. The factors that contribute to this are numerous. Doctors, hospital administrators, and government officials can all do their part to control certain aspects of these costs. However, one of the most important means of controlling the cost of medical care is patient involvement. Many patients do not take proper care of themselves or they delay getting needed medical care until the problem becomes too serious to go unattended.

In view of this, the Medical Association of Georgia feels that one way to reduce medical costs is by placing a strong emphasis on preventive health care. This is the basis for a new Healthy Lifestyles campaign which MAG has developed. The primary objective of this campaign is to promote healthy lifestyle choices among Georgians. Areas being emphasized include alcohol, drug and nicotine addiction; weight control, exercise, and good nutrition; seat belts and drunk driving; stress; and AIDS.

We will be using television and newspaper public service announcements, media kits, posters, brochures, a speakers bureau, information kits, and a 15-minute video for Georgia schools to relay our theme of "Healthy Lifestyles — Your Prescription For Life" to the public. However, as in the past with our "It's O.K. to Tell" and "You Can Say No" campaigns, one of the most effective ways we can spread our message is through you — the concerned and caring members of the MAG. The success of the campaign requires the support of all of our members.

For your interest in MAG and all its endeavors, I thank you. I am optimistic about the success the Healthy Lifestyles campaign and all our future efforts will have because of your support. ■

Jack F. Menéndez

## NEW MEMBERS

Andeson, Bonnie L., Diagnostic Radiology — MAA — (Active N2), 1205 Lake Charles Dr., Roswell, GA 30075

Bray, David A., Internal Medicine — Gwinnett-Forsyth — (Active N1), 100 Medical Center Blvd., Lawrenceville, GA 30245

Browne, James D., Otolaryngology-Head & Neck Surgery — Whitfield-Murray — (Active N2), 1436 Broadrick Dr., Dalton, GA 30720

Carr, Felicia M., Otolaryngology-Head & Neck Surgery — Bibb — (Resident), 2484 Donald Ave., Macon, GA 31201

Clay, Henry T., Jr., Family Practice — Bibb — (Resident), 777 Hemlock St., Macon, GA 31208

Cobiella, Angel M., Internal Medicine — MAA — (Service), 507 Park St., P.O. Box 499, Palmetto, GA 30268

Cook, Arthur J., Jr., Internal Medicine/Cardiovascular Diseases — MAA — (Active), 1938 Peachtree Rd. Ste. 103, Atlanta, GA 30309

Critz, Ann D., Pediatrics — MAA — (Active), 35 Linden Ave., NE Atlanta, GA 30309

Deese, Jack M., Orthopedic Surgery — Tift — (Active), 1610 John Orr Dr., Tifton, GA 31793

Delgado, Nestor F., Internal Medicine/Gastroenterology — Clayton-Fayette — (Active), 107 Upper Riverdale Rd., Riverdale, GA 30274

Elliott, Van B., Family Practice — Lumpkin — (Active), 103 Laurel Heights, Dahlonega, GA 30533

Franklin-Mintlow, Dinah L., Anesthesiology — MAA — (Active N2), 3241 Linda's Circle, Conyers, GA 30208

Friedland, Lance B., Cardiology/Internal Medicine — Gwinnett-Forsyth — (Active N1), 601-A Professional Dr., Lawrenceville, GA 30245

Gladin, Collier B., Jr., Cardiology/Internal Medicine — Bibb — (Resident), 784 Spring St., Macon, GA 31201

Gould, Jeffrey L., Diagnostic Radiology — Gwinnett-Forsyth — (Active), 2160 Fountain Dr., Snellville, GA 39278

Green, Agnes P., Anesthesiology — MAA — (Active N2), 639 Garden Walk Blvd., #504 College Park, GA 30349

Griffin, Donald L., Family Practice — Tift — (Active N2), 1843 Lee Run, Lilburn, GA 30247

Hicks, Winnie C., Family Practice — Bibb — (Resident), Medical Center of Central GA, Box 88, Macon, GA 31208

Johnson, Michele W., Pediatrics — Floyd-Polk-Chattooga — (Active), 16 Hospital Circle, Rome, GA 30161

Jones, Steven R., Pediatrics — Richmond — (Resident), 1105 15th St., #B-2, Augusta, GA 30901

Lafuente, Nancy, Family Practice — Colquitt — (Active), 700 South Main, Moultrie, GA 31768

Levine, David J., Dermatology — MAA — (Active N2), 993-D Johnson Ferry Rd., Ste. 100, Atlanta, GA 30342

Cepero, Cayetano A., Physical Medicine & Rehabilitation — Gwinnett-Forsyth — (Active), 5865 Jimmy Carter Blvd., Norcross, GA 30071

Mahvi, Kathleen A., Anesthesiolog — Lumpkin — (Active N2), 100 Overlook Point, Dahlonega, GA 30533

Palmer, Samuel E., Anesthesiology — Bibb — (Resident), 2543 Chelsea Dr., Macon, GA 31211

Patel, Pravinchandra H., Internal Medicine — Muscogee — (Active), 700 Center St., Ste. 201 Columbus, GA 31901

Paul, Raj, Plastic Surgery — South Georgia — (Active), 2301 University Dr., #2, Valdosta, GA 31602

Pollack, Alexander L., General Surgery — Spalding — (Active N1), 965 McDonough Rd., Jackson, GA 30233

Potter, Jack B., Internal Medicine/Allergy — MAA — (Active N2), 555 Peachtree Dunwoody Rd., Ste. 325, Atlanta, GA 30342

Prasse, Karen W., Internal Medicine/Allergy — Bibb — (Resident), 2951 Rolling Rd., Macon, GA 31204

Rast, Philip R., Urology — Dougla — (Active), 2550 Windy Hill Rd Marietta, GA 30067

Shay, John F., General Practice — Altamaha — (Active), Jeff Davis Medical Care Center, Hazelhurs GA 31539

Shonkoff, David W., Cardiology — MAA — (Resident), 1322 Briarwood Rd., #C-14, Atlanta, GA 30319

nmons, Clyde G., Pediatarics — Tift — (Active), 802 East 18th St., Tifton, GA 31794

lch, Norman Spencer, Diabetes/ Endocrinology — MAA — (Active N2), 35 Collier Rd., Ste. 650, Atlanta, GA 30309

aphart, Wilfreida L., Diabetes/ Endocrinology — Bibb — (Student), 1363 Stadium Dr., #102-D, Macon, GA 31201

## ERSONALS

*dwin CMS*

**HENRY D. ALLEN, JR.,** age 93, was honored recently by mer employees of Allen's Invalid me. State Senator Culver Kidd of ledgeville welcomed those sent and gave congratulatory arks to Dr. Allen and his family. a letter to Dr. Allen, Lt. Gov. Zell ler praised him saying, "The zens of the middle Georgia area l, indeed, the entire state owe a great debt of gratitude for the ny contributions you have made ard improving our quality of ." Lt. Gov. Miller went on to nt out Dr. Allen's omplishments in the area of lth care which include work at state hospital, as a Baldwin nty Health officer, service with American Psychiatric ociation, and president of both Baldwin County Medical iety and the Medical ociation of Georgia. Dr. Allen been involved in community vice as president and director of Merchants and Farmers Bank in Milledgeville, president of the Chamber of Commerce, a charter member of the Kiwanis Club, vice-president of Lockerly Arboretum, and president of the Baldwin County Farmers' Club.

*Ben Hill-Irwin CMS*

**FITZGERALD RADIOLOGIST Richard L. Benson, M.D.,** age 62, recently won Second Place in the 10,000 meter, Third Place in the 5,000 meter, and Fourth in the 1,500 meter races at the National Master's Track meet in Eugene, Oregon. Dr. Benson competed in the 60-64 year age group. His wins now qualify him to compete in the World Championship in December in Melbourne, Australia.

*Cobb CMS*

**MARTHA A. MORRISON, M.D.,** has been elected President of the Medical Staff at Ridgeview Institute in Smyrna. Specializing in adolescent chemical dependence, Dr. Morrison is Director of the Adolescent Chemical Dependence Program at Ridgeview.

*Hall CMS*

**JOHN L. SPEAR, M.D.,** of Gainesville, was recently selected as one of 104 Fellows named by the American College of Radiology at its September meeting in San Diego, California.

*Henry CMS*

**JOE U. CHOI, M.D.** has recently opened a practice in internal medicine and oncology in Stockbridge. He is on the staff of Henry General Hospital.

*Martha A. Morrison, M.D.*
*President*
*1987-88 Ridgeview Medical Staff*

*Medical Association of Atlanta*

**RICHARD J. KAROL, M.D.,** has joined the staff of North Fulton Medical Center in Roswell in the practice of general surgery and colorectal surgery.

*South Georgia CMS*

SELECTED FOR HIS outstanding contributions to the field of radiology, **Robert B. Quattlebaum, M.D.,** of Valdosta, was named as one of the 104 Fellows by the Board of Chancellors of the American College of Radiology at its annual meeting last September.

*Tift CMS*

**SOMSAK WATTANAWANAKUL, M.D.,** of Dawson, recently assumed the duties of chief radiologist at the Berrien County Hospital. Prior to accepting this position, he was employed as the chief radiologist at the Terrell County Medical Center in Dawson.

## DEATHS

Retired Trion general practitioner **William U. Hyden** died last February after nearly 40 years of active practice. He had been retired since 1977.

Dr. Hyden was a graduate of the University of West Virginia and the medical school at the University of Arkansas. In addition to his medical practice, he was very active in the community via farming, real estate, and banking activities, and as a sports enthusiast.

Dr. Hyden is survived by his wife, a daughter and son, three grandsons, other relatives, and inlaws.

## QUOTES

*American businessmen are always ready to scrap worn-out machines but slow to scrap worn-out ideas.*
EUGENE G. GRACE

*Nothing is more wearisome or more futile than the most antiquated of all manias: the rage to be modern.*
PAUL HINDEMITH

*Men of mettle turn disappointments into helps, as the oyster turns into pearls the sand which annoys it.*
ORISON SWETT MARDEN

*The man who trusts other men will make fewer mistakes than he who distrusts them.*
CAMILLO DI CAVOUR

*What's the matter with this country? No country ever had more, and no country ever had less. Ten men in our country could buy the whole continent of North America, and 10 million can't buy enough to eat."*
WILL ROGERS

*A determined soul will do more with a rusty monkey wrench than a loafer will accomplish with all the tools in a machine shop.*
RUPERT HUGHES

*The first spat in love, as the first misstep in friendship, is the only one we can turn to good use.*
JEAN DE LA BRUYÈRE


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## NOVEMBER

)-22 — *Atlanta:* **MAG Annual Sci-ntific Assembly.** Category 1 edit. Contact MAG, 938 Peach-ee St., Atlanta 30309. PH:404/876-535 or 1-800-282-0224 (toll free in a.).

## DECEMBER

-3 — *Atlanta:* **MAG Mutual Good ractice Seminars.** Category 1 edit. Contact Wanda Duren, MAG utual Insurance Company, P.O. ox 52979, Atlanta 30355. PH: 404/ 42-5600 or 800/282-4882 (toll free Ga.).

5 — *Atlanta:* **From Head to Toes rthopaedics for the Primary are Physician.** Category 1 credit. ontact Office of CME, Emory Univ. ch. of Med., 1440 Clifton Rd., At-nta 30322. PH:404/727-5695.

— *Atlanta:* **Anticholinergic Ther-y: New Treatment in the Man-gement of Patients with Ob-ructive Lung Diseases.** Category credit. Contact Office of CME, mory Univ. Sch. of Med., 1440 ifton Rd., Atlanta 30322. PH:404/ 27-5695.

6 — *Atlanta:* **Regional Anes-esia, Surgery, Obstetrics, and ain.** Category 1 credit. Contact Of-e of CME, Emory Univ. Sch. of ed., 1440 Clifton Rd., Atlanta )322. PH: 404/727-5695.

11 — *Atlanta:* **Magnetic Reso-ance Imaging.** Category 1 credit. ontact Office of CME, Emory Univ. ch. of Med., 1440 Clifton Rd., At-nta 30322. PH:404/727-5695.

-15 — *Atlanta:* **Quantitative allium Myocardial Tomogra-y.** Category 1 credit. Contact Of-e of CME, Emory Univ. Sch. of ed., 1440 Clifton Rd., Atlanta )322. PH:404/727-5695.

## JANUARY 1988

22-23 — *Atlanta:* **MAG Annual Leadership Conference.** Contact MAG staff, 938 Peachtree St., Atlanta 30309. PH:404/876-7535 or 800/282-0224.

22-23 — *Atlanta:* **Vitreoretinal Seminar.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

## FEBRUARY

4-9 — *Atlanta:* **American Academy of Orthopaedic Surgeons Annual Meeting.** Category 1 credit. Contact AAOS, 222 S. Prospect, Park Ridge, IL 60068. PH:312/823-7168.

5-6 — *Atlanta:* **Georgia Psychiatric Association.** Category 1 credit. Contact James M. Moffett, 938 Peachtree St., Atlanta 30309. PH:404/876-7535 or 800/282-0224 (toll free in Ga.).

7 — *Atlanta:* **Cancer Care in Community Hospitals. II. The Hospital-Based Cancer Program.** Category 1 credit. Contact Janet Bonfiglio, RN, American Cancer Society, Ga. Div., 46 5th St., Atlanta 30308. PH:404/822-0026.

17 — *Atlanta:* **Pulmonary Forum.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

20 — *Atlanta:* **Advances in the Treatment of Coronary Artery Disease.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/727-5695.

26-27 — *Augusta:* **Flexible Sigmoidoscopy.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/228-3967.

## MARCH

7-12 — *Augusta:* **Annual Family Practice Symposium.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/228-3967.

10-17 — *Copper Mountain, CO:* **Snow Job in Gynecology and Obstetrics.** AMA Category 1 and ACOG credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton RD., Atlanta 30322. PH:404/727-5695.

11-12: *Atlanta:* **25th Annual Ophthalmology Conference.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH:404/ 727-5695.

24-26 — *White Sulphur Springs, WV:* **Tenth Annual Pediatric Postgraduate Course.** Sponsored by Scottish Rite Children's Hospital. Category 1 credit. Contact Darlene Baugus, SRCH, 1001 Johnson Ferry Rd., Atlanta 30363.

25-26 — *Atlanta:* **Hoke Kite Symposium on Children's Orthopaedics.** Sponsored by Scottish Rite Children's Hospital. Category 1 credit. Contact Darlene Baugus, SRCH, 1001 Johnson Ferry Rd., Atlanta 30363.

27-31 — *Atlanta:* **American College of Cardiology.** Category 1 credit. Contact ACC, 9111 Old Georgetown Rd., Bethesda, MD 20814. PH:301/897-5400.

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## CDC Issues Revised AIDS-Safety Guidelines

THE CENTERS for Disease Control recommends that hospitals treat all patients as if they were infected with the human immunodeficiency virus (HIV). GHA has developed an AIDS manual for hospitals that carries guidelines for preventing AIDS transmission in health care settings. It also includes the revised CDC surveillance case definition for AIDS as well as guidelines for antibody testing and counseling and sample policies that hospitals can use to develop their own policies.

## Joint Commission Adopts New Name

THE JOINT COMMISSION of Accreditation of Hospitals has changed its name to the Joint Commission on Accreditation of Healthcare Organizations. Commission president Dennis S. O'Leary notes that the name change will mean the end of the familiar "JCAH" acronym, but adds that "we already refer to ourselves simply as the 'Joint Commission' and would prefer this reference in the future." The change came because the organization accredits long-term care facilities, ambulatory care organizations, mental health facilities and programs, and hospices in addition to hospitals.

HOSPITAL NEWS is sponsored by the Georgia Hospital Association.

## Hospital Requirements Regarding Participating Physicians

TO ENCOURAGE more physicians to accept Medicare assignment, the government now requires hospitals to make the *Participating Physician Directory* available to patients. When hospital personnel refer a patient to a nonparticipating physician, they must tell the patient that the physician may not accept assignment. They must also give the patient the name of at least one physician listed in the directory who provides the type of services the patient needs.

## Medicare Beneficiaries May Get Hefty Increase In Their Part B Premiums

HHS OFFICIALS recently confirmed that Medicare's nearly 32 million beneficiaries may be hit in 1988 with a 38.5 percent increase in Part B monthly premiums — the largest since the program's inception. The premium rate hike — to $24.80 per month from the current $17.90 — largely reflects a surge in the volume of physician services.

HCFA Administrator William L. Roper, M.D., said Part B outlays had soared 20 percent during the first six months of 1987 compared to the same period in the previous year. In comparison, Part A outlays for hospital services increased about 5 percent during the corresponding period. HCFA projects that Part B outlays in 1987 will top $29 billion, up from $26.2 billion in 1986. Roper said that beneficiaries' premiums had been held "artificially low" in 1986 and 1987, and he labeled the 38 percent increase in monthly premiums next year "a catch-up jump."

## AHA Settles Lawsuits With Iowa Chiropractors

THE AHA Sept. 8 settled two related antitrust lawsuits, both of which were filed by a committee of the Iowa Chiropractic Society in U.S. District Court for the Southern District of Iowa (Des Moines). Under terms of the settlement, the AHA admitted no violation, fault, or liability in the case. The committee of chiropractors had charged that the AHA and a number of co-defendants conspired to restrain the practice of chiropractic in Iowa.

Although the District Court had granted the AHA's motion for summary judgment on the original complaint in August, 1986, the plaintiff appealed to the U.S. Court of Appeals for the 8th Circuit in December, 1986. The other defendants named in the lawsuit were not included in the settlement.

The AHA agreed as a condition of the settlement to send copies of the following statement to the CEO's of all Iowa hospitals and to publish it in *AHA News:*

'The AHA affirms that its policy regarding the actice of chiropractic in a ospital setting is set forth and affirmed in paragraph 7 of an greement dated June 13, 1987, ong and between the plaintiffs d the AHA in *Wild et al. vs. the nerican Medical Association et*, Civil Action No. 76 C 3777, in United States District Court for Northern District of Illinois, stern Division, Judge Susan tzendanner.

'The AHA acknowledges that for purpose of issuing licenses to d regulating doctors of iropractic, who are duly licensed practice chiropractic in Iowa, Iowa General Assembly has fined "chiropractic" in Chapter 1 of the Iowa Code with the most ent amendments being enacted 1983.

'The AHA acknowledges that ctors of chiropractic, to be ensed in Iowa, are required by va law to take courses and pass aminations in the physical and sciences, but has no owledge of the content of these urses and the quality of truction given.

The AHA further acknowledges t to the extent permitted by law, h Iowa hospital may decide for lf whether the institution and ividual pathologist, radiologist, other health care professionals bloyed by or associated with h Iowa hospital may provide ology services, laboratory ices or other hospital-based ices for, and/or previously ormed radiology services, oratory services or other pital-based services, to opractors licensed in Iowa and/ hiropractic patients."

## *Survey Shows Southern Hospitals Bear Greatest Burden of AIDS Inpatient Costs*

HOSPITALS IN THE SOUTH have been hardest hit by the costs of AIDS inpatient care, according to a survey conducted by the National Association of Public Hospitals, Washington, D.C. Data from 169 public and teaching hospitals indicated that Southern hospitals are losing almost twice as much money on care for AIDS patients as facilities in other regions of the nation. The study links the regional differences to lower Medicaid reimbursement and a substantially greater amount of charity care provided at Southern hospitals. As a result, these hospitals are losing more than $9,000 per AIDS patient per year. The 169 hospitals in the survey treated about 29 percent of all AIDS inpatients in 1985.

## *PPS For Home-health Services Seen In 1989*

HCFA AND HOME-HEALTH AGENCY (HHA) representatives are crafting a prospective-pricing system (PPS) for Medicare-certified HHAs to take effect in FY 1989. Medicare now pays home-health agencies for costs incurred, but HHAs have complained that HCFA is increasingly denying payment claims. HCFA denied 6 percent of all home-health claims submitted in 1986, compared with 1.2 percent in 1983, according to the National Association of Home Care (NAHC), Washington, DC.

Many claims are denied after care is given, forcing Medicare patients or HHAs to absorb the cost, an NAHC spokeswoman said. Of the 5,877 Medicare-certified home-health agencies, 1,417 are hospital-based.

NAHC Director of Research and Development Robert Hoyer said some HHA operators support PPS for home care because it would ensure payment, but others have expressed concern that HCFA will deny patients eligibility for care. HCFA says it has denied claims because patients either do not fit the Medicare criteria of "homebound" or they do not need intermittent care.

* * *

*If you get simple beauty and naught else, you get about the best thing God invents.*
ROBERT BROWNING

*Happiness consists in the attainment of our desires, and in having only right desires.*
SAINT AUGUSTINE

*The man or woman who has "heart" can adorn the mansion house of his memory with treasures richer than those of Golconda, with images more beautiful than the paintings and statuary of the ancients. The priceless things of life, happily, are as accessible to the poor as to the rich.*
B.C. FORBES

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The Wesley Woods Geriatric Hospital is staffed and designed to address the complex physical, social, emotional and spiritual needs of the elderly. Outpatient services include a comprehensive health evaluation with the availability of medical specialists. Inpatient treatment units include an Alzheimer's Disease/Dementia Unit, a Psychiatry Unit, a Medical Unit and an Assessment Unit.

The Wesley Woods Hospital doesn't look like a hospital. Overlooking Peachtree Creek in a wooded setting, everything about the hospital, from the gray and white New England style exterior, to the warm peach-colored interior, is designed around one theme — the comfort and care of our patients and families.

The hospital is part of the Wesley Woods Center. The Center offers a variety of services to older people and their families including residential retirement living, intermediate care and skilled nursing care, respite care, Alzheimer's Disease care, family consultation and family counseling.

Admissions to the hospital can be made directly or through referral. Wesley Woods Hospital has an open medical staff so all physicians are invited to make an application.

Wesley Woods Hospital services are provided without regard to race, creed, color, national origin, handicap condition or age. Certified to participate in Medicare or Medicaid. Call (404) 728-6380 for further information.

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# A Comparison of Alcoholics and Cocaine Addicts One Year Following Inpatient Treatment

**Howard M. Strickler, M.D., Carolyn A. Martin, Ph.D., Raymond H. Sowell, Jr., M.D., Al J. Mooney, III, M.D.**


## ABSTRACT

*The assumption that cocaine addiction is essentially different from alcoholism and that recovery from it is more difficult than from alcoholism is widely held by the general public as well as the medical community and implies the need for special treatment for cocaine addicts. Following a survey of the literature which yielded no follow-up studies comparing the two groups, a retrospective study was undertaken, comparing alcoholics and cocaine addicts 1 year or longer following their treatment in a combined treatment program. Forty-seven cocaine-addicted patients comprised the experimental group and were matched with alcoholics on selected variables. Twenty-nine matched pairs comprised the final sample. No significant difference in outcome status was found for the two groups. Results of the study showed that combined treatment was as effective for cocaine addicts as for alcoholics.*


SUBSTANCE ABUSE and addiction affect a larger number of people, directly and indirectly, and cost the country more in lost income and production than does any other health problem.[1] Recent estimates place the cost for medical treatment of alcoholism and related illnesses at $79 billion[1] and the total cost to the 6economy for alcoholism and alcohol abuse at $117 billion.[2] When costs for addiction to other drugs are included, total 1983 estimates were almost $176 billion.

From 20 to 60% of the patients in hospitals are being treated for complications of alcoholism.[2,4] The majority of alcoholics are never treated, and the majority of those who do seek treatment are not diagnosed with alcoholism[2] but are often treated for other illnesses and conditions alcoholism contributes to or imitates.

Published accounts of the highly addictive qualities of cocaine and the fatal effects of "crack" on young, healthy sports figures (even on initial use) have left the general public with the belief that cocaine addiction is essentially different from


Dr. Strickler, currently in private practice of Family Medicine and Addictionology in Birmingham, AL, conducted this study as part of his Fellowship in Addictionology at Willingway Hospital, in association with the Faculty Development Fellowship Program in Family Medicine at the University of North Carolina at Chapel Hill School of Medicine.

Dr. Martin is Director of Research for Willingway Foundation, Statesboro, GA.

Dr. Sowell is a staff psychiatrist at Georgia Regional Hospital, Savannah, GA.

Dr. Mooney is Director of Willingway Hospital, Statesboro.

Send reprint requests to Dr. Strickler, 9002-C Parkway East, Birmingham, AL 35206.

addiction to alcohol. They believe that special treatment is required for cocaine addicts and that stable recovery is more difficult for cocaine addicts to achieve than for alcoholics. Some physicians in the medical community also hold this same view.

Cocaine has generally been considered the drug of choice of young white males of high socioeconomic status. With the introduction of low cost "crack," cocaine use is becoming more widespread among people of various backgrounds and at even younger ages. Since cocaine use frequently results in rapid addiction, cocaine addicts might be expected to be in treatment at an earlier age than alcoholics.

Among those who work in the field of chemical dependency, alcoholism and drug addiction are widely believed to be variations of a unitary illness.[5-7] Different patients have different drugs of abuse, but the basic disease is the same. In studying addiction, investigators must examine the people who are addicted as well as the substances to which they are addicted.[8, 9] Their varying characteristics and experiences, including patterns of drug use, are a part of their history and will in some ways influence their recovery.

Most patients now have more than one drug of abuse,[10] and many treatment facilities treat alcoholics and drug addicts together in the same program.[9] The unitary illness philosophy provides the basis for the individualized treatment program of Willingway Hospital in Statesboro, Georgia, and is described in detail elsewhere.[9] Basically, since its inception 15 years ago, Willingway has treated the hospitalized patient and his or her family as a unit and has individualized its program for each addicted patient-family, while retaining a generic approach as to the nature of the disease. The treatment goal is the same for all patients: To help them learn to live without mood altering drugs (including alcohol) while acquiring some measure of serenity as they gain relief from their compulsion to use drugs and gain skill in interacting with other people in their lives. Committed to the principles of Alcoholics Anonymous (AA) and based on the careful cultivation of self-discipline, treatment helps patients develop their individual programs of recovery as well as actively participate in self-help groups. The treatment plan takes into consideration each patient's experiences and needs, but it treats the generic disease of addiction, using alcoholism as the prototype.

***Among those who work in the field of chemical dependency, alcoholism and drug addiction are widely believed to be variations of a unitary illness. Different patients have different drugs of abuse, but the basic disease is the same.***

Although it is generally assumed that there are major differences between alcoholics and cocaine addicts, a review of the literature has revealed no comparative study of patients treated for alcohol and cocaine addiction in a combined treatment program. Some researchers, who note differences within the cocaine group, believe that there may be a greater variation in the severity of addiction and related conditions among cocaine addicts than among those addicted to other drugs.[11-13] This variety may contribute to their lack of identification with others in treatment and therefore to their denial of chemical dependence.[12]

Smith and Wesson[14] also note this variation as well as the increasing prevalence of multiple abusers among cocaine addicts seeking treatment generally. Washton,[15] in a random sampling of young cocaine users who called the 800-COCAINE hotline in 1984, found that 82% used alcohol to counteract the unpleasant effects of cocaine, 64% used sedative hypnotics, and 92% used marijuana.

If it is logical to assume that a large percentage of cocaine addicts also abuse alcohol and other drugs, then a combined treatment program should offer the most flexible and effective treatment. Many cocaine addicts believe that because of their drug of choice, they are unique or at least have special needs which cannot be met in a hospital which treats alcoholics. However, we believe that these needs can be addressed in a combined program and without losing sight of the main task — recovery from addiction.

The current study was designed to test the hypothesis that if alcohol and drug addiction are accepted as variations of the same disease and similar individualized treatment is provided for all patients, then there should be no significant difference in the treatment outcomes for alcoholics and cocaine-addicted patients who complete their prescribed regimen.

### Methods and Subjects

The treatment population came primarily from the southeastern part of the United States. Two groups of former patients were selected from the total number who completed treatment at Willingway Hospital in 1983 and 1984. The experimental group (N=48) was composed of patients who, on admission, listed their drug of choice as cocaine. A

comparison group was comprised of patients who, on admission, listed their drug of choice as alcohol and who could be matched to a member of the cocaine group on the following variables: sex, race, age (within 5 years), and admission date.

To compare the two groups for abstinence status and involvement with self-help organizations since treatment, a six-item survey instrument was designed. Data were obtained on four dimensions: (1) Total abstinence (being free of all mood altering chemicals since leaving the hospital); (2) Current abstinence (free of all mood altering chemicals for the past 6 months); (3) Participation in Alcoholics Anonymous (AA) or Narcotics Anonymous (NA); and (4) Additional treatment for addiction subsequent to discharge from the treatment center. Two other items provided additional relevant data by: (5) Identifying the person answering the questionnaire, and (6) Recording deceased patients' date of death.

In February, 1986, the questionnaire was sent to each of the 94 patients in the study. Five weeks later, another copy was mailed to the non respondents. Thirty-four completed questionnaires were returned as a result of these two mailings. A total of 43 questionnaires were completed by staff telephone interviews with the patient or a knowledgeable informant. If the patients could not be located, the emergency contact listed on the admission form was called. This person was usually a family member or Employee Assistance Program (EAP) Director who knew the former patient well enough to provide accurate answers.

**TABLE 1 — Subjects Classified By Abused Drug For Selected Demographic Characteristics**

| | *Alcohol Group* | | *Cocaine Group* | |
|---|---|---|---|---|
| | *Number* | *Percent* | *Number* | *Percent* |
| **Age:** | | | | |
| Range | 22-42 | | 20-41 | |
| Mean | 31.2 | | 30.7 | |
| Median | 31 | | 31 | |
| Mode | 30 | | 26 | |
| Sample Size | 29 | | 29 | |
| **Marital Status:** | | | | |
| Never married | 4 | 14 | 13 | 45 |
| Presently married | 13 | 45 | 7 | 24 |
| Separated/divorced | 12 | 41 | 9 | 31 |
| | 29 | 100 | 29 | 100 |
| | | | $X^2=6.993$ (p=.03) | |
| **Occupational Status:** | | | | |
| Working as trained | 23 | 79 | 21 | 72 |
| Below Training | 2 | 8 | 3 | 10 |
| Unemployed | 1 | 3 | 2 | 8 |
| Unknown | 3 | 10 | 3 | 10 |
| | 29 | 100 | 29 | 100 |
| **Legal Status** | | | | |
| No charges | 19 | 66 | 24 | 83 |
| Charges Pending | 5 | 17 | 2 | 7 |
| Current Probation | 4 | 14 | 2 | 7 |
| Past Probation | 0 | 0 | 1 | 3 |
| Unspecified | 1 | 3 | 0 | 0 |
| | 29 | 100 | 29 | 100 |
| | | | $X^2=2.367$ (p=.31)* | |
| **Education Level** | | | | |
| Elementary School | 7 | 25 | 3 | 10 |
| H.S. Diploma | 10† | 36 | 7 | 24 |
| Some College | 7 | 25 | 12† | 42 |
| College Degree | 3 | 11 | 5 | 17 |
| Graduate Study | 1 | 3 | 2 | 7 |
| | 28‡ | 100 | 29 | 100 |
| | | | $X^2=4.259$ (p=.37) | |

* Current Probation, Past Probation, and Unspecified were pooled for purposes of statistical analysis.
† Alcohol Group Median Level = High School Diploma
Cocaine Group Median Level = Some College
‡ Information not stated for patients missing from the total.

## Results

At the end of the study, 77 (81.9%) questionnaires had been completed; 40 were from the alcohol group and 37 from the cocaine group. Eight questionnaires in each group were completed by telephone interviews with persons other than the former patient. One patient in the cocaine group was deceased, having relapsed following discharge; however, the actual cause of death is unknown.

Since the responses from the groups were unequal in number, unmatched responses were deleted from the sample to maintain the original study design. Twenty-nine matched pairs comprised the final sample. The exclusion of the unmatched respondents in no way altered the conclusions from the study.

Selected demographic characteristics of the final sample are summarized in Table 1. Seventy percent of the patients were white, 30% were black; 85% were male, 15% were female. They ranged in age from 20 to 42 years (median = 31). The Cocaine Group had a significantly higher percentage of single patients (p = .03) and tended to have more formal education and

a lower crime rate. Otherwise, the groups had very similar demographic characteristics.

Table 2 presents selected measures of drug problems prior to beginning treatment. Most of the patients in the study were new to Willingway. The Alcohol Group had a higher prevalence of family history of alcoholism than the Cocaine Group. Otherwise, the groups were quite similar.

After entering treatment, each patient's urine was screened for alcohol and cocaine. The test results and other selected treatment experiences are contained in Table 3.

***The remission rate was not significantly different for the two groups nor did the comparison of chart data for the groups yield significant differences in demographic or treatment variables, with the exception of marital status.***

Table 4 presents selected measures of treatment outcome. One-third (10 of 29) of the alcohol patients and almost half (14 of 29) of the cocaine patients reported being totally abstinent since discharge from treatment, with some additional patients reporting being sober 6 months preceding the interview (Table 2). More than half of each group reported involvement in AA or NA since treatment, and less than half reported receiving further treatment for their addiction subsequent to leaving treatment.

In looking at those in each group who had remained sober, it was found that five (50%) of the 10 al-

**TABLE 2 — Subjects Classified By Abused Drug For Selected Indicators of Alcohol/Drug Related Problems Prior to Treatment**

| | *Alcohol Group* | | *Cocaine Group* | |
|---|---|---|---|---|
| | *Number* | *Percent* | *Number* | *Percent* |
| **AA Involvement:** | | | | |
| None | 13 | 45 | 17 | 59 |
| Some | 16 | 55 | 12 | 41 |
| | 29 | 100 | 29 | 100 |
| **Previous Admission to Willingway:** | | | | |
| None | 26 | 92 | 28 | 96 |
| One Time | 1 | 4 | 1 | 4 |
| >One Time | 1 | 4 | 0 | |
| | 28* | 100 | 29 | 100 |
| **Previous A & D Treatment Elsewhere:** | | | | |
| None | 15 | 52 | 17 | 61 |
| One Time | 8 | 27 | 8 | 28 |
| >One Time | 6 | 21 | 3 | 11 |
| | 29 | 100 | 28* | 100 |
| **Suicide Attempts Prior to Admission:** | | | | |
| None | 15 | 52 | 16 | 55 |
| Thoughts only | 11 | 38 | 9 | 31 |
| Plan | 1 | 3 | 0 | |
| Attempt | 2 | 7 | 4 | 14 |
| | 29 | 100 | 29 | 100 |
| **Family History of Alcoholism:** | | | | |
| None | 11 | 39 | 19 | 66 |
| Parent | 12 | 43 | 6 | 20 |
| Other | 5 | 18 | 4 | 14 |
| | 28* | 100 | 29 | 100 |
| | | | $X^2 = 4.228$ ($p = .12$) | |

* Information not stated for patients missing from the total.

**TABLE 3 — Subjects Classified By Abused Drug For Selected Treatment Experiences**

| | *Alcohol Group* | | *Cocaine Group* | |
|---|---|---|---|---|
| | *Number* | *Percent* | *Number* | *Percent* |
| **Urine Screen for Alcohol:** | | | | |
| Positive | 8 | 29 | 5 | 17 |
| Negative | 20 | 71 | 24 | 83 |
| | 28* | 100 | 29 | 100 |
| | | | Corrected $X^2 = .495$ ($p = .48$) | |
| **Urine Screen for Cocaine:** | | | | |
| Positive | 1 | 4 | 8 | 28 |
| Negative | 26 | 96 | 21 | 72 |
| | 27* | 100 | 29 | 100 |
| | | | Corrected $X^2 = 4.274$ ($p = .04$) | |
| **Days on Unit I:** | | | | |
| Median | 7 | | 9 | |
| Min.-Max. | 4-58 | | 5-16 | |
| **Days on Unit II:** | | | | |
| Median | 22 | | 33 | |
| Min.-Max. | 0-50 | | 14-49 | |
| **Family Participation in Treatment Program:** | | | | |
| Acceptable | 19 | 68 | 22 | 76 |
| Unacceptable | 9 | 32 | 7 | 24 |
| | 28* | 100 | 29 | 100 |

* Information not stated for patients missing from the total.

**TABLE 4 — Subjects Classified By Abused Drug For Selected Treatment Outcome Variables**

| | *Alcohol Group* | | *Cocaine Group* | |
|---|---|---|---|---|
| | *Number* | *Percent* | *Number* | *Percent* |
| **Abstinence:** | | | | |
| **Total** | 10 | 35 | 14 | 48 |
| **Past 6 months** | 5 | 17 | 2 | 7 |
| **Not Abstinent** | 14 | 48 | 13 | 45 |
| | 29 | 100 | 29 | 100 |
| **AA/NA Involvement Since Treatment:** | | | | |
| **Yes** | 15 | 52 | 18 | 62 |
| **No** | 14 | 48 | 11 | 38 |
| | 29 | 100 | 29 | 100 |
| **Subsequent Treatment Since Discharge:** | | | | |
| **Yes** | 7 | 24 | 6 | 21 |
| **No** | 22 | 76 | 23 | 79 |
| | 29 | 100 | 29 | 100 |
| **Questionnaire completed by:** | | | | |
| **Former patient** | 23 | 79 | 24 | 83 |
| **Other** | 6 | 21 | 5 | 17 |
| | 29 | 100 | 29 | 100 |

coholics and 12 (86%) of the 14 cocaine addicts who reported total abstinence since discharge from treatment also reported involvement in AA or NA. For the five alcoholics who had 6 months sobriety, 69% reported further treatment subsequent to leaving Willingway, and 80% reported involvement in AA. Fifty percent of the cocaine group who had been sober for 6 months reported further treatment and involvement in AA/NA. Only one of the questionnaires for the two sober groups was completed by someone other than the former patient.

Fewer of those in each group who had not maintained sobriety since leaving treatment reported involvement in AA or NA; only 43% of the practicing alcoholics and 38% of the practicing cocaine addicts were involved in AA or NA. Four (29%) of the alcoholics and five (38%) of the Cocaine Group reported further treatment. Just over 60% of each of the non sober groups completed the questionnaires for themselves (64% and 62%, respectively).

## Discussion

Our clinical hypothesis was not disproved. The remission rate was not significantly different for the two groups nor did the comparison of chart data for the groups yield significant differences in demographic or treatment variables, with the exception of marital status. The groups did differ somewhat on level of education, which was not controlled.

Relapse may be more common among younger patients today regardless of the drug of choice than for the current general treatment population or that of a decade ago. The average age and the remission rate for both groups in the study were lower than those reported in an unpublished 10-year follow-up study (currently underway) of the treatment population of the same facility.

## Conclusions

The pharmacologic action of cocaine is vastly different from that of alcohol, and certainly some differences in treatment are often necessary relative to the drug of choice and total exposure to the drug, e.g., the detoxification protocol, as well as length of stay in treatment. Certain types of counseling and guidance regarding particular individual issues may also be required to help patients adopt a different lifestyle, but that need exists for the alcohol group as well as for the cocaine group.

Over 20 years ago Jellinek[16] remarked that the only two things that were constant in alcoholism were alcohol and damage. The same can be said of the broader category of chemical dependency — the presence of mood altering chemicals and damage. Variety of symptoms and experiences is one of the characteristics of the disease; hence, diagnosis must be made by examining alcohol and other drugs' cumulative effects in various areas of life rather than by attempting to document any one consistent course of the illness. Yet it is still believed to be a unitary disease. The findings of this study did not produce any evidence to the contrary.

Four obvious limitations of the study are: (1) Consideration of drug of choice as equivalent to major drug of abuse; (2) Lack of consideration of other substances abused (and the extent of abuse) by patients in both groups; (3) Not matching for education level; and (4) The sole use of self-report data, rather than including a more objective measure of recovery status.

***Variety of symptoms and experiences is one of the characteristics of the disease; hence, diagnosis must be made by examining alcohol and other drugs' cumulative effects. . . .***

Further investigation is needed to determine factors related to relapse and remission of addiction in alcoholics and cocaine addicted patients as well as others. Within group comparisons of selected variables on the totally abstinent and the never abstinent might reveal psychosocial and physiologic profiles of those who have successfully stayed sober and identify the obstacles for those who were unable to do so. Some evidence was found that involvement in AA or NA was correlated with staying sober, and no apparent differences were found for the two groups.

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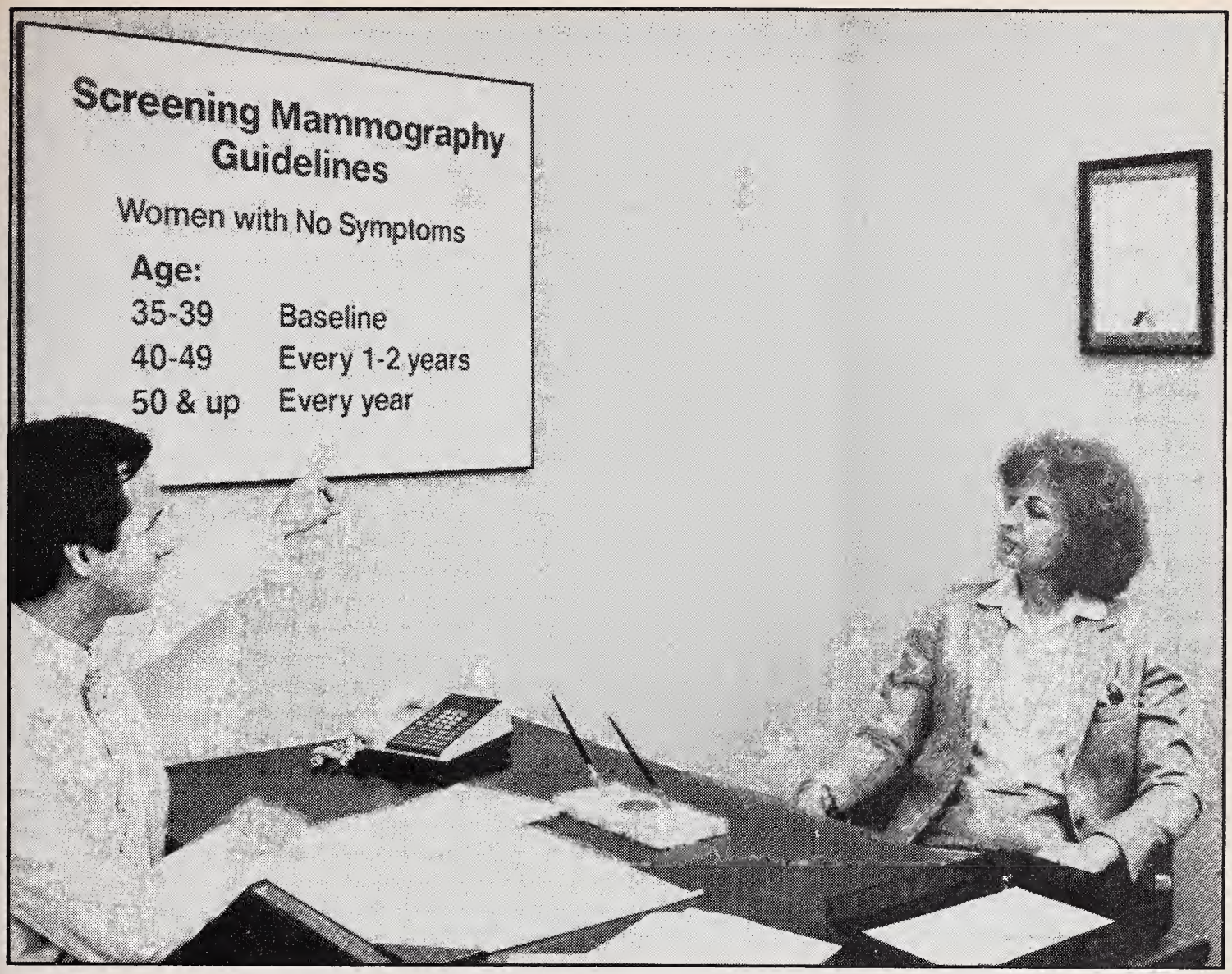


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# AMA Comes to the Peach State

# American Medical Association Interim House of Delegates December 6-9, 1987 Marriott Marquis Hotel Atlanta

FOR THE THIRD TIME in its 140-year history — and the first time in this century — the American Medical Association will convene its semi-annual House of Delegates in Atlanta. The AMA meeting, which will be held December 6-9 at the Marriott Marquis Hotel, is very much a special occasion for Georgia physicians and for the Medical Association of Georgia.

As the principal decision-making body of the AMA, the House of Delegates consists of over 400 delegates, representing state medical associations, national specialty societies, and special sections (e.g., hospital medical staffs, medical schools). Among this number, the MAG holds seats for seven delegates, with seven alternate delegates elected to assist them.

The AMA House functions much like MAG's. After opening ceremonies, Reference Committees offer forums for discussion of reports and resolutions. After hearing this testimony, Reference Committees then offer specific recommendations (adopt, not adopt, amend, etc.) for each item. The House receives these recommendations, debates the issues, and votes, thus setting AMA policy.

This December the House will open on Sunday afternoon, December 6 at Atlanta's new Marriott Marquis. Reference Committees will hold their hearings on Monday; *all physicians* are entitled to express opinions on issues before the Reference Committees. House debate and voting will follow on Tuesday and Wednesday.

If the last session of AMA House is any indication, this December's meeting will have a hefty agenda. Last June, meeting in Chicago, the AMA extensively discussed AIDS, physician dispensing, PROs, physician DRGs, and Medicare reimbursement. The House adopted positions on these issues, as well as on a multitude of public health matters (such as tobacco use). A number of these items, especially AIDS, will again dominate the agenda of the AMA House in Atlanta later this year.

But the delegates' schedule will not be all work. On Sunday evening, December 6, the Medical Association of Georgia and the Southern Medical Association will host an "Evening at the High," at the High Museum of Art. A reception and musical entertainment will be part of the evening's schedule.

The Hospital Medical Staff Section will meet Friday, Dec. 6, from 8 am to 6 pm at the Westin Peachtree Plaza. All doctors are encouraged to attend. At 2:30, special issues regarding AIDS and medical staffs will be addressed.

The AMA's decision to come to Atlanta speaks well for the amenities offered to conventioneers in our capital city, but it also reflects the Medical Association of Georgia's prominence in the AMA. The recent term of Atlanta's Harrison Rogers, Jr., M.D., as President of the American Medical Association is an obvious example. In addition, Dr. Charles Hollis, Jr., of Albany, has recently assumed the chairmanship of the Southeast Delegation — an alliance of twelve states (plus the District of Columbia) whose combined strength of 84 delegates allows Georgia and her sister states to wield considerable influence in House elections. The service of other MAG members in AMA Council positions — such as the participation of Augusta's Dr. Karolyn Kramer on the AMA Council of Medical Education — attests also to MAG's notable contribution to AMA activities. ■

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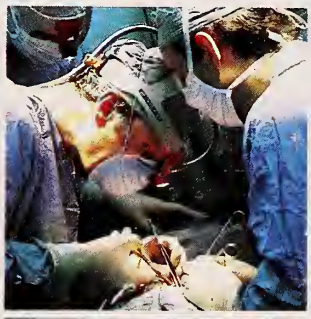

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# Organ and Tissue Donation, 1987

P.A. Bowen, M.D.,
A.L. Humphries, M.D.,
M.A. House, R.N., M.S.N.,
A.R. Mansberger, M.D

## *A harvest of hope*

*Illustration by Sue Allinder, Medical College of Georgia*

## Introduction

IMPROVEMENTS in patient management and selection, better understanding of the immune response to allogenic tissue, and more potent and selective immunosuppressive medications have markedly increased the utilization and success rates of vital organ transplantation. This has broadened the applicability of organ replacement therapy for many patients suffering from organ failure. In addition, the utilization of donated tissues such as heart valves, corneas, skin, bone, and dura continues to expand at a tremendous rate.

***Despite a tremendous amount of publicity in this area, it has been reported that only 20% of Americans carry donor cards and that this pool of donors accounts for no more than 15-20% of all organs and tissues donated.***

Currently, there is a nationwide shortage of vital organs and tissues. With widespread use of better matching techniques, blood transfusions, immunosuppressive medications such as cyclosporine A, and a variety of antilymphocyte preparations (e.g., ALS, ATGAM and OKT3 PAN), the number of vital organ transplants performed has shown a steady increase over the past several years. Despite the increased number of transplants performed, the increase in success rates has led to broader criteria for which a patient can be considered a transplant candidate, and the list of potential recipients awaiting a transplant continues to grow. Table 1 shows the number and types of transplant procedures performed for the years 1982 through 1985 and the approximate number of patients who are waiting for each type of transplant in 1987. These data are derived from the International Transplant Registry. In the patient who needs a kidney transplant, this gap between the needy patients and the supply of cadaveric kidneys can be partially erased by altruistically motivated living donation. Such donation, of course, runs the risk of injuring the otherwise healthy donor, but most studies reveal that it is, in fact, safe for a healthy person to donate a kidney to a needy recipient. This altruistically motivated living related donation is obviously not possible for patients in need of other vital organ or tissue transplants. Because of this drastic shortage of vital organs and tissues, public and professional awareness and legislative commitment to increasing cadaveric vital organ and tissue recovery will be necessary.

From the Departments of Medicine and Surgery, The Medical College of Georgia, Augusta. Send reprint requests to P. Allen Bowen, II, M.D., Nephrology Section BA N-644, Medical College of Georgia, 1120 Fifteenth St., Augusta, GA 30906-2363.

## Categories of Donors

Before proceeding further with a discussion of policy models for improving the recovery of vital organs and tissues, we must clarify the distinction between vital organ donor and tissue donor. The criteria which identify suitable candidates for the variety of organs and tissues which can be donated are shown in Table 2. Vital organ donors are patients who have suffered an irreversible cessation of brain function as defined by the Georgia brain death law.

***Some studies indicate that between 20 and 30 thousand patients per year suffer brain death in such a way as to be a suitable vital organ donor. Yet, only about 3 to 4 thousand . . . actually become vital organ donors.***

These individuals must be free of transmissible infection or malignant disease, and the cause of death must be known. These brain dead patients are carefully maintained in an intensive care facility, and fluid and electrolyte status is optimized until organ recovery can be accomplished. Many, but not all, such patients can be considered for multiorgan recovery. Heart, liver, and heart-lung donors must be closely

## TABLE I
## Transplant Type, Number and Waiting List

| Organ | Transplants Performed in U.S. 1982 | 1983 | 1984 | 1985 | Approx. No. of Patients on Waiting Lists |
|---|---|---|---|---|---|
| Kidney | 5,358 | 6,112 | 6,968 | 7,800 | 9,000 |
| Heart | 103 | 172 | 346 | 719 | 350 |
| Heart/Lung | | 13 | 29 | 37 | 125 |
| Liver | 62 | 164 | 308 | 602 | 400 |
| Pancreas | 35 | 61 | 87 | 136 | 30 |

### Table II: ORGAN & TISSUE DONOR CRITERIA

| | KIDNEY | HEART | HEART/ LUNG | LUNG | LIVER | PANCREAS | BONE | SKIN | EYE |
|---|---|---|---|---|---|---|---|---|---|
| Age | 6 mos-65 | 0-50 | 2-40/45 | 1-50 | 0-50 | 1-60 | 16-60 | 14-75 | no limits |
| Cardiac Arrest resuscitated | Proo OK | No | No | Possibly | Prob OK | Prob OK | Heart beating cadaver not mandatory | Heart beating cadaver not mandatory | Heart beating cadaver not mandatory |
| Chest/Abd trauma | Important | Extremely Important | Extremely Important | Extremely Important | Extremely Important | Important | Little Importance | Not Important | Not Important |
| No active infections | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory |
| No previous disease of organs | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory |
| No presence or history of communicable disease | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory |
| Hypotension | Sensitive | Very Sensitive | Very Sensitive | Very Sensitive | Sensitive | Sensitive | N/A | N/A | N/A |
| Vasopressor, i.e Dopamine Sensitive | Yes | Very | Very | N/A | Very | Yes | N/A | N/A | N/A |
| Weight important | No | Yes | Yes | Yes | Yes | No | No | > 100 lbs | N/A |
| Body Build important | No | Yes | Yes | Yes | Yes | No | No | No | No |
| Blood type | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory | Mandatory | No | Occasionally |
| Additional physician consults required | Usually not | Yes | Yes | Yes | Possibly | Usually not | No | No | No |
| Additional lab needed | Yes Kidney specific | Yes Heart specific | Yes Heart/lung specific | Yes Lung specific | Yes Liver specific | Yes Pancreas specific | No | No | No |
| Time needed to set up additional teams | Usually Not | Yes | Yes | Yes | Yes | Yes | Possibly | Possibly | Usually Not |

matched for body size as well as ABO blood group compatibility. Distribution of kidneys is predicated upon need, matching criteria, ABO compatibility and is mitigated, by the concern to avoid excessive cold ischemia times with its concomitant deleterious effect on overall renal allograft success rate. Vital organ donors can, of course, also serve as donors for tissues such as cornea, skin, bone, soft tissue, and dura. On the other hand, tissue donors are individuals who have suffered cardiac death and would not be suitable vital organ donors. Yet much benefit can be reaped by recovery of cornea, skin, bone, soft tissue, and dura.

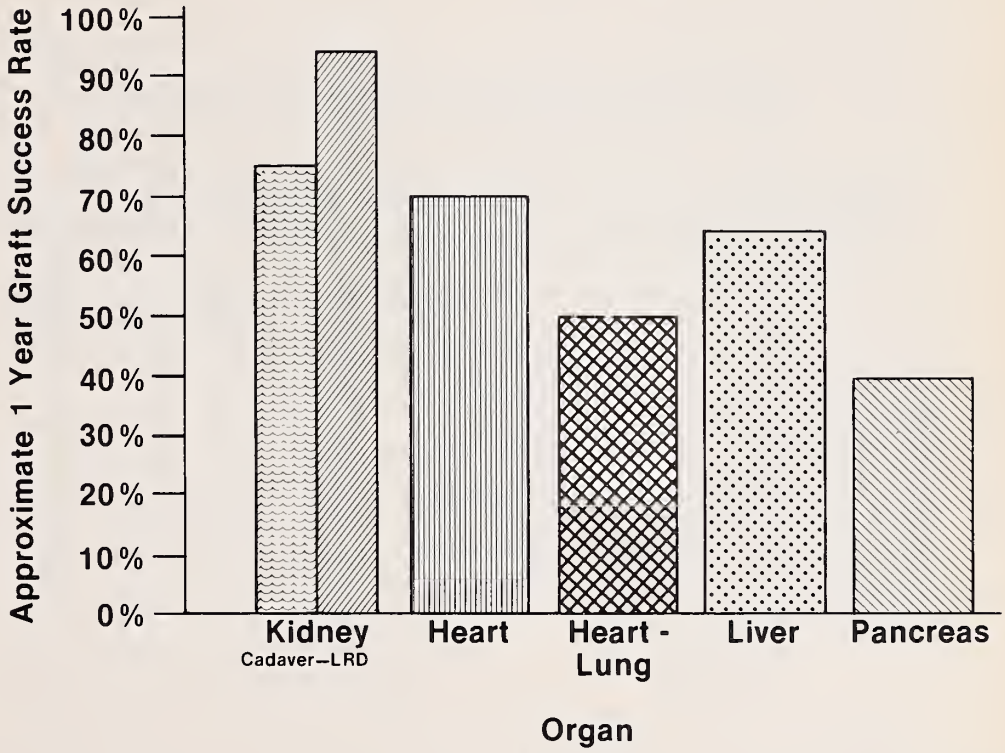
An approximate average across the nation for a 1-year allograft survival rate for renal and extrarenal vital organs is shown in Figure 1. These figures are derived from The International Transplant Registry. These survival statistics are dramatically superior to those obtained in the era prior to the widespread use of cyclosporine A and other potent immunosuppressives.

### Why the Shortage of Cadaveric Organs and Tissues?

It is important to address the issues of why the supply of cadaveric organs and tissues falls short of the need. Some studies indicate that between 20 and 30 thousand patients per year suffer brain death in such a way as to be a suitable vital organ donor. Yet, only about 3 to 4 thousand patients per year actually become vital organ donors. Thus, it is obvious that our current efforts fall far short of addressing the goal of making a transplant available for any patient in need. Currently, the system used to recover vital organs and tissues has been referred to as "encouraged voluntarism."[1] This system relies heavily on public awareness of the mechanics of and the needs for vital organs and tissues; and it revolves around making donor cards available so that enlightened citizens can make their wishes known. Despite a tremendous amount of publicity in this area, it has been reported that only 20% of Americans carry donor cards and that this pool of donors accounts for no more than 15 to 20% of all organs and tissues donated.[2] These facts are appalling, especially in light of the enormous amounts of time, effort, and money

spent on public and professional awareness about the importance of donation. Indeed, some investigators feel that the primary reason for the low rate of donation is that health care professionals are either not trained in the importance of the issue or are unwilling to request donation. Some studies have reported that when family members have been approached regarding vital organ and tissue donation, an acceptance rate for donation approaching 70% will be found regardless of whether the donor carried a donor card or not.[3, 4] Thus, it is obvious that a policy change aimed at increasing both public and professional awareness of the need for organ donation and that a system to increase the likelihood that the family will be approached regarding donation needs to be implemented.

**Fig. 1 : Approximate Survival Rates**




### Alternative Organ and Tissue Recovery Policies

One policy aimed at increasing the supply of cadaveric organs and tissues has been tried in several European countries. This model is known as "assumed consent," wherein the individual is assumed to consent to organ and tissue donation unless an objection is known to exist or the objection is raised by the family. This policy is costly and expensive to administrate. In addition, since it places the burden of refusal to donate on the family, it could lead, if improperly presented, to an abrogation of individual autonomy over one's own body and raises serious ethical questions regarding individual freedom versus societal needs. This policy has not been demonstrated to be superior to the current policy used in this country.

Another model proposed to optimize organ and tissue recovery is known as "required request." A modification of this model has recently been passed into Georgia law (O.C.G.A. 44-5-140) and became effective July 1, 1987. Under this system, reliance is placed upon the willingness of patients and their family members to donate when appraised of the need and are actually asked to do so.[5] Under this type of system, the hospital becomes responsible for notifying an appropriate organ or tissue procurement agency when an appropriate donor is identified. The procurement agencies are made responsible for educating hospital personnel in their service area to be able to identify appropriate organ and tissue donors. Thus, Georgia legislation closely follows the federal guidelines set forth in 1984 establishing a nationwide organ procurement network to ensure fair and equitable distribution of vital organs and tissues. Organ procurement agencies in Georgia will participate in this network under the guidelines of the United Network for Organ Sharing (UNOS). As noted above, if roughly 70% of the families asked to donate will do so, this system offers hope for an increase in vital organ and tissue recovery. In addition, this policy preserves the autonomy of the individual and his family in regards to respecting wishes of the patient and/or the family for disposition of his body.

### Financial, Religious and Funeral Aspects of Organ and Tissue Donation

Professional and lay people alike, often have questions regarding the financial, religious, and mechanistics aspects of organ and tissue donation. Concerning the financial aspects of donation, these are basically neutral for the family in that they are not billed nor do they receive financial remuneration for donation. Many studies, however, have reported that the donors' families are left with a positive feeling after donating, in that even though they have sustained a tragic loss, they may have improved the quality of life for many other patients. While some religious sects are not amenable to organ and tissue donation, the governing bodies of all major

Protestant, Catholic, and Jewish sects support organ and tissue donation. Some families express concerns regarding funeral arrangements for the deceased. In general, the funeral arrangements need not be delayed for the patient who becomes a vital organ or tissue donor. None of the procedures done during vital organ or tissue recovery interfere with a normal open casket funeral. Many families express concern over how the donated organs and tissues will be utilized. As noted before, kidney recipients are matched on the basis of ABO blood group and other compatibility factors utilizing the local and national sharing network such as the United Network for Organ Sharing (UNOS). Extra-renal vital organs are ABO and size compatible for the potential recipient and are distributed on the basis of most urgent need.

### Summary

There has been a dramatic expansion and an improvement of success rates in organ and tissue transplantation. Despite this improvement, there continues to be a great increase in the number of patients who await vital organ and tissue transplantation. Despite an increased number of vital organ and tissue transplants performed, the supply of organs and tissues still falls far short of the goal. By legislative mandate, hospitals will be required to have an active ongoing relationship with organ and tissue procurement agencies and to refer as potential donors all patients identified as satisfactory candidates. It is hoped that this policy change will increase the supply of vital organs and tissues. There remain many ethical, scientific, societal, and legislative issues to be addressed in optimizing the delivery of this precious and scarce resource. An issue of critical concern, as long as there remains such a desperate scarcity of vital organs, is whether the organs should be allocated preferentially to those in most critical need or to the individual most likely to achieve long-term success. These issues can be addressed only in a social and legislative forum. If the supply of vital organs and tissues were adequate to meet the demand, then such hard questions need not be answered and all recipients in need could be served.

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# Idiopathic Thrombocytopenic Purpura in Childhood: A Current Perspective

**Hernan Sabio, M.D., Virgil C. McKie, M.D., P. Charlton Davis, Jr., M.D.**

***Although controversy remains in the management of ITP, current laboratory techniques . . . provide additional parameters which may impact on the management of children with acute and chronic forms of thrombocytopenia.***

### Background

IDIOPATHIC THROMBOCYTOPENIC PURPURA (ITP) is one of the more common blood disorders of children. In its acute form, it is clinically characterized by the sudden appearance of purpura, petechiae, and ecchymoses in an otherwise healthy person who might have recovered from an acute, presumably viral, illness during the preceding weeks. The cardinal laboratory features are isolated thrombocytopenia, with a normal hemoglobin, hematocrit and white blood cell count and differential. Bone marrow examination eliminates the possibility of aplastic anemia, leukemia, or neuroblastoma by demonstrating normal or increased numbers of megakaryocytes in the presence of normal bone marrow elements.

ITP in children is clinically different from its counterpart in adults. The majority of affected children will have a normal platelet count 6 months after diagnosis. Only 5-10% will show persistent thrombocytopenia 1 year later. The threat of intracranial hemorrhage (ICH) at the time of diagnosis, even though estimated to be less than 1%, does implore the clinician to initiate therapy, usually with corticosteroids. Splenectomy is reserved for pediatric patients who have severe thrombocytopenia (platelet count <20,000/dl) persisting 12 to 18 months after diagnosis. Splenectomy is usually avoided or delayed in children with ITP because of the risk of overwhelming sepsis occurring in splenectomized individuals.

Dr. Sabio specializes in pediatrics/hematology, Dr. McKie in pediatrics/hematology, and Dr. Davis in pediatrics/hematology. Send reprint requests to Dr. Sabio, Associate Professor of Pediatrics, Department of Pediatrics, Room CK-150, Medical College of Georgia, Augusta, GA 30912.

### Platelet Antibodies

Newer diagnostic and therapeutic approaches now alter the management of ITP in children. It is known that the thrombocytopenia observed in ITP is mediated through the action of antibodies directed at antigenic sites on the platelet membrane. Thus, idiopathic thrombocytopenic purpura is more aptly termed immune thrombocytopenic

purpura. The precise determination of platelet antibodies present in serum or attached to the platelet membrane is available to the clinician. Since the specific binding sites of the antibodies cannot always be determined, these antibodies are referred to as platelet-associated immunoglobulin-G (PAIgG). Recent studies suggest that PAIgG levels at the time of diagnosis might discriminate between the patients who experience chronic thrombocytopenia and those who experience a prompt recovery.[1] High levels of PAIgG at the time of diagnosis appear to indicate an acute course with complete recovery. Thus, minimal therapeutic intervention is anticipated. Lower levels of PAIgG suggest a greater risk for developing chronic thrombocytopenia. This latter group of patients also requires careful repeated evaluations for other evidence of autoimmune disease such as systemic lupus erythematosus. The presence of PAIgG, however, does not establish a diagnosis of ITP. Immunoglobulins can be bound to the platelet membrane in other conditions such as infection or drug reactions. Immune-mediated thrombocytopenia in infancy can be secondary to systemic viral infections such as cytomegalovirus or human immunodeficiency virus (HIV).[2] Recognition of PAIgG does, however, provide confirmatory evidence of the clinical diagnosis of ITP and in its indirect form (circulating antibodies) may serve as a marker or indicator of the disease.[3]

### Intravenous Gammaglobulin

Independent observations of improving platelet counts in patients with thrombocytopenia who had received plasma or gammaglobulin (IgG) for the treatment or prevention of serious infection associated with immune deficiency led to the development of a new therapy for ITP. Intravenous gammaglobulin (IVGG) administered in high doses was found to increase the platelet count in patients with thrombocytopenia and hypogammaglobulinemia. These findings suggested that the high levels of circulating immunoglobulins were affecting the rate of platelet removal from the circulation. The hypothesis was tested by administering IVGG to children with chronic ITP. Favorable responses were observed in most of these children. Subsequently, several studies have clearly demonstrated the effectiveness of IVGG in the treatment of children with chronic ITP. This is particularly important since it provides an alternative to splenectomy for the child with thrombocytopenia. The dose of IVGG utilized most frequently is 400mg/kg daily for 5 consecutive days, although a single dose of 1,000mg/kg also appears to be effective.[4] Some children with chronic ITP experience a complete response and do not require additional treatment with IVGG. However, others require booster doses at 3 to 6-week intervals to maintain the platelet count in a hemostatic range.

***Recent studies suggest that PAIgG levels at the time of diagnosis might discriminate between the patients who experience chronic thrombocytopenia and those who experience a prompt recovery.***

IVGG may also play a role in the treatment of the child newly diagnosed with ITP. If there is extreme thrombocytopenia (< 10,000 platelets/μl) and active bleeding, the use of IVGG offers the possibility of a rapid rise in the platelet count (approximately 20,000 platelets/μl/day). It is also indicated for the child who develops ITP during the course of varicella and has significant bleeding.

The side effects of IVGG include flushing of the face, fever, chills, headache, nausea, and vomiting. These are infrequent and are eliminated by prolonging the infusion time of the IVGG.[5] Immediate anaphylactoid reactions due to previous sensitization of the recipient to certain antigens, most commonly IgA, may be infrequently observed. IVGG does not appear to have a risk for the transmission of HIV infection.[10]

The most significant objections to the use of gammaglobulin for the treatment of the patient newly diagnosed with ITP are the cost of the drug and the anticipated full recovery of 90% of children with ITP. The use of IVGG will not affect the morphology of the bone marrow.

IVGG is especially useful in the acute management of the child who has experienced intracranial bleeding, a major mucosal hemorrhage from the genitourinary or gastrointestinal tract, or in the setting of emergency surgery. It is anticipated that its use will accelerate the recovery of the platelet count where platelet transfusions are not expected to be effective because of

the presence of platelet antibodies and rapid removal of the transfused platelets from the circulation. IVGG has been utilized effectively in the antenatal and perinatal management of isoimmune thrombocytopenia.[6]

Very high doses of corticosteroids, i.e. prednisone 8mg/kd/day, have also been advocated in the treatment of acute ITP associated with bleeding. This potentially toxic therapy requires very careful monitoring of the patient for signs of toxicity and should only be of brief duration.[7] A bone marrow examination is mandatory if a child with suspected ITP is to be treated with corticosteroids.

**Table 1 — Platelet Indices**

| | Aplastic Anemia | Acute Leukemia | ITP |
|---|---|---|---|
| Platelet count | ↓ | ↓ | ↓ |
| MPV | N1 | N1 | ↑ |
| PDW | N1 | N1 | ↑ |

### Platelet Indices

Currently available flow-type blood cell counters provide new information in the evaluation of thrombocytopenia. In addition to the quantitative platelet count, a measurement of the mean platelet volume (MPV) is also generated. The MPV is analogous to the mean corpuscular volume (MCV) available for red blood cells. The MPV is determined through the electronic measurement of the volume of individual platelets and is usually increased when there is a greater proportion of young platelets in the circulation.[8] An increase in these young platelets results in the higher MPV observed in thrombocytopenic states associated with increased bone marrow production of platelets such as ITP. In addition, the distribution of platelet sizes is determined and can be quantitated by the platelet distribution width (PDW). An elevated PDW denotes increased variability in the size of platelets. This phenomenon is also observed in conditions associated with rapid removal of platelets from the circulation in the presence of normal or increased bone marrow function. These new platelet indices can aid the clinician in the evaluation of thrombocytopenia in children (Table 1).

### Summary

For many years, clinicians have quibbled over whether or not to treat (usually with corticosteroids) the child with ITP.[9] Although controversy remains in the management of ITP, current laboratory techniques (platelet antibodies and platelet indices) provide additional parameters which may impact on the management of children with acute and chronic forms of thrombocytopenia. This new information is adjunctive to the appropriate diagnosis and management of children with ITP. The most important initial diagnostic laboratory procedure in the evaluation of suspected thrombocytopenia is a complete blood count. Efforts directed at preventing or minimizing bleeding should not be overlooked. These include the avoidance of aspirin and aspirin-containing products and appropriate restrictions to avoid trauma. The most important element in management is determining if therapy is actually indicated. Corticosteroids may effectively increase the platelet count in children with ITP. IVGG has been shown to rapidly increase the platelet count and may be of benefit when a rapid increase is critical to control bleeding. IVGG is also helpful in the treatment of children with prolonged (chronic) severe ITP and may delay or avoid the need for splenectomy.

### References


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CARAFATE®
(sucralfate)

BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate.

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

**Drug Interactions:** Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

**Pregnancy:** Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

**Pediatric Use:** Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED
CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712. Issued 3/84

References:
1. Grossman MI: *Scand J Gastroenterol* 58 (suppl 15):7-16, 1980.
2. Marks IN, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly.* Edinburgh, Churchill Livingstone, 70-81, 1984.
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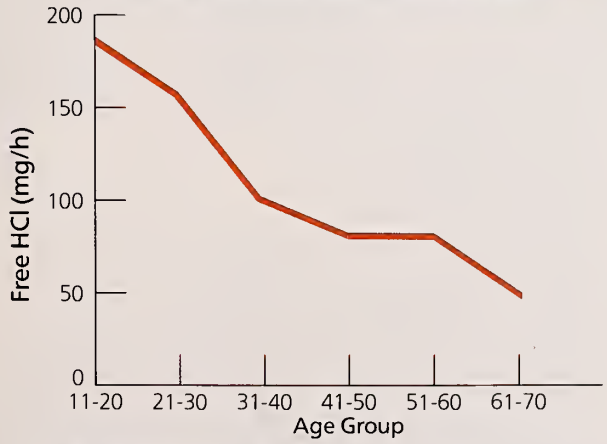
*Specialized ulcer therapy*

# When advancing age signals reduced acid secretion

If your duodenal ulcer patient is over 55, decreased mucosal resistance is more likely to cause an ulcer than hypersecretion of acid-pepsin.[1] A tendency toward lower acid secretion with advancing age has been shown.[2,3]

Declining gastric secretion and age[3]




CARAFATE® (sucralfate/Marion) makes sense as initial ulcer therapy for the elderly. Carafate provides ulcer healing rates comparable to $H_2$ antagonists without the risk of systemic side effects or drug interactions—an important benefit for older patients.

The unique, nonsystemic action of Carafate enhances the body's own ulcer healing ability, strengthening the mucosal structure as it protects damaged tissue from further injury.

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Please see adjoining page for references and brief summary of prescribing information.

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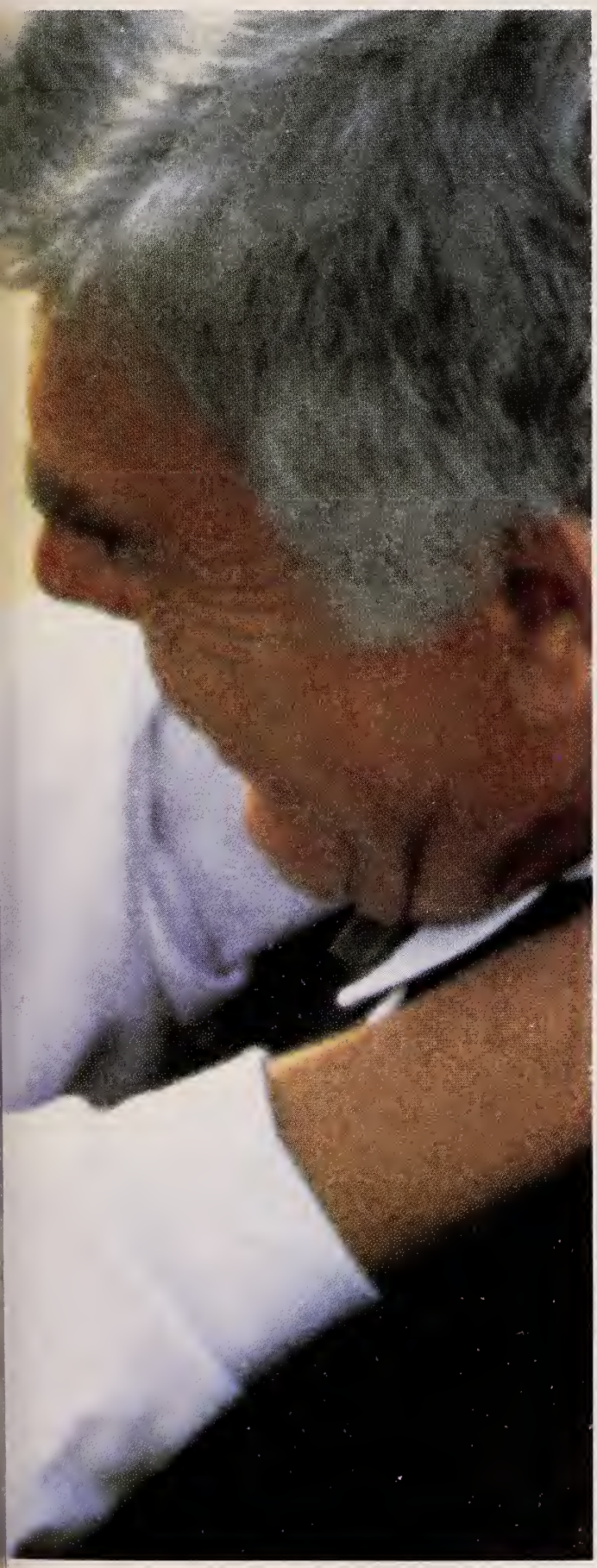

## Proven benefits beyond relief of vasomotor symptoms

## No other estrogen proven effective for osteoporosis

Only conjugated estrogens tablets have established efficacy in both osteoporosis[1] and vasomotor symptoms* at 0.625 mg/day. No other estrogen, oral or transdermal, has established clinical evidence or minimum effective dose in both indications.

## No estrogen proven safer

PREMARIN is the most extensively tested estrogen, with an unsurpassed record of long-term safety.
And clinical evidence shows a significantly reduced risk of endometrial hyperplasia when cycled with a progestin.[2]

# PREMARIN®
(conjugated estrogens tablets)

## Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

# For moderate-to-severe vasomotor symptoms and for osteoporosis

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(conjugated estrogens tablets)

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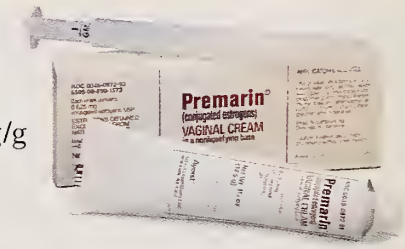
# For atrophic vaginitis

# PREMARIN®
(conjugated estrogens)

Vaginal Cream

0.625 mg/g




BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

**PREMARIN® Brand of conjugated estrogens tablets, USP**
**PREMARIN® Brand of conjugated estrogens Vaginal Cream, in a nonliquefying base**

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA.
Three independent, case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses.
2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.
The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimated a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

**DESCRIPTION:** PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

**INDICATIONS AND USAGE:** PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

**Concomitant Progestin Use:** The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

**CONTRAINDICATIONS:** Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (see Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

**WARNINGS:** Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning). However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nontatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

**PRECAUTIONS:** Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not yet complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.
b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3, increased norepinephrine-induced platelet aggregability.
c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, $T_4$ by column, or $T_4$ by radioimmunoassay. Free $T_3$ resin uptake is decreased, reflecting the elevated TBG; free $T_4$ concentration is unaltered.
d. Impaired glucose tolerance.
e. Decreased pregnanediol excretion.
f. Reduced response to metyrapone test.
g. Reduced serum folate concentration.
h. Increased serum triglyceride and phospholipid concentration.

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

**ADVERSE REACTIONS:** The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis; change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance, aggravation of porphyria; edema; changes in libido.

**ACUTE OVERDOSAGE:** May cause nausea, and withdrawal bleeding may occur in females.

**DOSAGE AND ADMINISTRATION:**

**PREMARIN® Brand of conjugated estrogens tablets, USP**

1. *Given cyclically for short-term use only.* For treatment of moderate-to-severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.
2. *Given cyclically:* Osteoporosis. Female castration. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off). Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

**PREMARIN® Brand of conjugated estrogens Vaginal Cream**

*Given cyclically for short-term use only.* For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three- to six-month intervals.

Usual dosage range: 2 g to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

**References:**

**1.** Lindsay R, Hart DM, Clark OM. The minimum effective dose of estrogen for prevention of postmenopausal bone loss. *Obstet Gynecol* 1984;63:759-763. **2.** Studd JWW, Thom MH, Paterson MEL, et al: The prevention and treatment of endometrial pathology in postmenopausal women receiving exogenous estrogens, in Pasetto N, Paoletti R, Ambrus JL (eds): *The Menopause and Postmenopause.* Lancaster, England. MTP Press Ltd. 1980, chap 13.

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***Dr. Barton performed the first laryngectomy in Middle Georgia . . . on a patient . . . who was also the first in the area to use an electric voice box supplied by the telephone company.***

# William L. Barton, M.D., A Pioneer in Otolaryngology

**Miguel A. Faria, Jr., M.D.**

IT BEHOOVES the medical profession to recognize its outstanding contributors, reflecting not only on the credit of the individual so recognized but also on the profession as a whole. With this in mind, I would like to recognize Dr. William L. Barton, a retired otolaryngologist who served the Middle Georgia community for nearly half a century.

Dr. Barton was born in Macon, Georgia, on November 16, 1909, and there he attended public schools. He received his B.S. degree from Mercer University with a major in chemistry and his M.D. degree from the Medical College of Georgia in 1935. In 1952, he became a member of Alpha Omega Alpha, the honorary medical fraternity. From 1935 to 1936, he served an internship at the old Macon Hospital, which is now the Medical Center of Central Georgia. He then went to New York City, where he served a residency in otolaryngology at Columbia Presbyterian Hospital Medical Center. He returned to his home town in 1940 and practiced otolaryngology until his retirement in 1985. I had the pleasure of meeting Dr. Barton personally and learning of his many accomplishments during the last 2 years of his long practice.

He filled the position of Chief of Service in the Ear, Nose, and Throat Department of the Macon Hospital

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from 1941 to 1961. He remained as consultant for the Macon Tumor Clinic as well as visiting physician for the Milledgeville State Hospital for 15 years.

Dr. Barton was a Diplomate of the American Board of Otolaryngology, a member of the American College of Surgeons, and a member of the International College of Surgeons. In addition, he was a member of the Pan American Association of Broncho-Esophagology and a senior fellow of the American Broncho-Esophagological Association. He remained active in numerous medical association activities, including those of the American Medical Association, the Southern Medical Association, Medical Association of Georgia, and the Bibb County Medical Society.

He served as President of the Alumni Association of the Medical College of Georgia and was a founding member of the Medical College of Georgia Foundation. He is presently a member of the Medical College of Georgia President's Club.

Dr. Barton was recognized in 1969 by the American Council of Otolaryngology for outstanding dedication to the well-being of his patients. In addition, he was awarded the Distinguished Physician's Award by the Medical College of Georgia in 1985.

Other accomplishments include the designing of several medical instruments, which included several nasal retractors and a skin retractor. He also designed a suspension laryngoscope which was an improvement of the old Lynch suspension concept. After he designed this model, many refinements have been made on this useful instrument.

Dr. Barton was selected Doctor of the Year of the Middle Georgia Region by the Bibb County Medical Society in 1984, and he was also featured in the National Encyclopedia of American Biography, Volume 1, 1960-63.

Perhaps the accomplishments Dr. Barton is most proud of are connected with his patients. He performed the first laryngectomy in the Middle Georgia area in 1940, assisted by Dr. Charles Ridley, Jr., on a patient from Eastman, Georgia, whom he remembers vividly. This same patient was also the first in the Middle Georgia area to use an electric voice box supplied by the telephone company.

He also performed the first procedure for bilateral abductor paralysis of the vocal cords in this area. He remembers draining petrous bones and frontal sinus abscesses that sometimes extended into the base of the skull. Because there were no neurosurgeons at that time in Macon, he repaired dural lacerations to stop cerebral spinal fluid leakages.

Word of Dr. Barton's accomplishments in broncho-esophagoscopy extended through South Georgia and into Florida. He used a 3.5 mm. bronchoscope. He remembers removing many peanuts, including one from a 5-year-old child with a peanut in the right main-stem bronchus. Another patient was a 3-year-old from Appalachicola, Florida, with a fishscale deep within the bronchial tree which was successfully extracted with a bronchoscope. A 13-year-old child presented with a sewing machine needle embedded deep in the parenchyma of the lower bronchus. This required turning the child upside down and allowing the needle to drop within reach of the magnet. The patient was then shaken several times until the needle suddenly dislodged and came in contact with the magnet.

***He remembers draining petrous bones and frontal sinus abscesses that sometimes extended into the base of the skull. Because there were no neurosurgeons at that time in Macon, he repaired dural lacerations to stop cerebral spinal fluid leakages.***

Another patient was referred to him by a friend, Dr. Harold Long of Eastman, Georgia, who was very proud of always making the correct diagnosis. The patient was referred as having swallowed a nickel. Dr. Barton enjoyed telling Dr. Long that he was wrong: there was a dime behind the nickel which he found.

Physicians such as Dr. Barton who have dedicated their entire life to the practice and advancement of medicine, especially when anesthesia and equipment were not as highly developed, deserve recognition. I salute Dr. William L. Barton and look forward to many more informative and pleasant chats in the lounges and cafeterias of our hospitals about the exciting moments in the history of medicine in Middle Georgia. He continues to add to our enjoyment of staff and medical association meetings.

# Metoclopramide-induced Galactorrhea

James O. Day, M.D., F.A.C.P.

***This case emphasizes the importance . . . of taking a careful drug history when evaluating patients with this problem. Failing to do so could risk subjecting a patient to needless anxiety and inconvenience as well as costly and invasive testing to rule out a pituitary tumor.***

METOCLOPRAMIDE has become widely used in the treatment of certain gastrointestinal disorders, such as vomiting, gastroparesis, and gastroesophageal reflux. It has generally proven to be a safe and well tolerated drug with few major side effects. Some of its common and well known side effects include drowsiness, restlessness, and extra-pyramidal reactions.

Metoclopramide-induced galactorrhea has been rarely reported in the literature, but its true incidence is unclear.[1,2] Since this drug effect is not well known, it may not be readily appreciated by the primary care physician who initially evaluates the patient with galactorrhea. The development of galactorrhea is thought to be related to metoclopramide's effect on prolactin secretion. Although metoclopramide is a known potent stimulator of prolactin secretion, the mechanism of this action is less certain.

A case of metoclopramide-induced galactorrhea is presented here, followed by a brief discussion of the mechanism of action and management of this potential side effect.

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### Case Report

A 34-year-old woman developed galactorrhea 4 months after starting metoclopramide for gastroesophageal reflux. She had no menstrual irregularities, and her last menses had occurred 2 weeks previously. There was no history of headaches, visual changes, or fertility problems. She had had two normal pregnancies, the last being 8 years previously and had breast fed without problems.

During the preceding 4 months, she took metoclopramide concomitantly with cimetidine. However, she had taken cimetidine regularly with no ill-effects for several months prior to starting metoclopramide. No other medications had been taken, including oral contraceptives.

Initial evaluation by her gynecologist yielded a normal prolactin blood level, and she was referred for further study. This initial pro-

lactin level was obtained after the patient had been off metoclopramide for several days.

Physical examination revealed a healthy appearing white woman with normal vital signs. There was no hirsutism, and skin and hair texture were normal. Thyroid was not enlarged, and visual fields were intact by confrontation. Breast examination confirmed copious galactorrhea. Deep tendon reflexes were normal and symmetrical. Pelvic examination was normal, as was the remainder of the physical examination.

Laboratory examination yielded normal blood chemistries and complete blood count. T-4 was 8.3 mcg/dl (normal 4.5-12.5), T-3 uptake was 29 percent (normal 25-35), and T-7 index was 2.4 units (normal 1.1-4.0).

While taking metoclopramide, serum prolactin level was markedly elevated at 176 mg/ml (normal 0-25). Serum prolactin level was again repeated off medication and found to be reduced to normal at 6 mg/ml.

Over the course of the next 3 months, after total withdrawal of all medications, the patient's galactorrhea completely resolved. She was then re-challenged with metoclopramide and after 1 day of therapy, developed expressable galactorrhea which resolved several days after discontinuation of the drug.

### Discussion

Galactorrhea is not an uncommon endocrine disorder and is usually related to hyperprolactinemia. It should be noted, however, that the relationship between prolactin levels and the development of galactorrhea is not always direct. Some women may have galactorrhea with fairly low prolactin levels, and others with high prolactin levels will have no galactorrhea.

Hyperprolactinemia is associated with several physiologic and pathologic conditions including pregnancy and postpartum, primary hypothyroidism, cirrhosis, chronic renal disease, and polycystic ovaries. Some pituitary adenomas may secrete large amounts of prolactin, as well.[3]

Prolactin secretion, is mediated by the hypothalamus and has no known negative feedback control from target organs. However, dopamine, which is produced in the hypothalamus, has been found to be a major prolactin-inhibiting factor. Thus, drugs which interfere with dopamine metabolism or uptake may result in hyperprolactinemia in some patients. The resulting hyperprolactinemia may be associated with not only galactorrhea but a variety of other clinical problems including amenorrhea, anovulation, and luteal-phase defects.[2-5] In addition to metoclopramide, examples of other drugs with this action include estrogens, phenothiazines, tricyclic anti-depressants, methyldopa, reserpine, and butyrophenones.[3, 5, 6]

***It should be noted . . . that the relationship between prolactin levels and the development of galactorrhea is not always direct.***

The commonly prescribed metoclopramide (Reglan) has been well documented to stimulate prolactin secretion and, in fact, has been used as a provocative test in studying prolactin secretion.[7-9] Only a few reports, however, have linked this drug to the development of galactorrhea.[1, 2] The primary care physician should be aware of this potential side effect, since this widely used drug may cause symptoms and biochemical abnormalities which are identical to those produced by a prolactin-secreting pituitary tumor. Furthermore, metoclopramide frequently stimulates prolactin serum levels to above 100 mg/ml which are more strongly suggestive of a pituitary tumor.[7]

In studies by Ano, et al., the appearance of galactorrhea after beginning metoclopramide therapy averaged 23 days but occurred as early as 3 days. After discontinuation of the drug, prolactin levels rapidly returned to normal in a majority of patients, while galactorrhea often persisted for several months or longer. In one patient whose galactorrhea and hyperprolactinemia persisted for over 3 months, bromocriptine therapy successfully resolved the galactorrhea and reduced prolactin levels to normal.[2]

This problem in most patients can be managed by simple withdrawal of the drug. However, a dilemma is created in the patient whose severe gastroesophageal reflux or other gastrointestinal problem is controlled only on metoclopramide therapy. Perhaps, in such patients, lower doses can be tried, but there are no studies to suggest the dosage reduction will reduce the incidence of galactorrhea. In addition, this drug and others known to stimulate prolactin secretion should obviously be avoided in the patient with a suspected prolactinoma, since it might tend to potentiate tumor growth.

### Summary

The case presented here describes a patient who developed galactorrhea only after metoclopramide was begun. A rechallenge confirmed the role of metoclopramide and prolactin.

This case emphasizes the importance of awareness of this potential side effect of metoclopramide and of taking a careful drug history when evaluating patients with this problem. Failing to do so could risk subjecting a patient to needless anxiety and inconvenience as well as costly and invasive testing to rule out a pituitary tumor. Withdrawal of the drug usually will result in clarifying the etiology fairly promplty in most cases.

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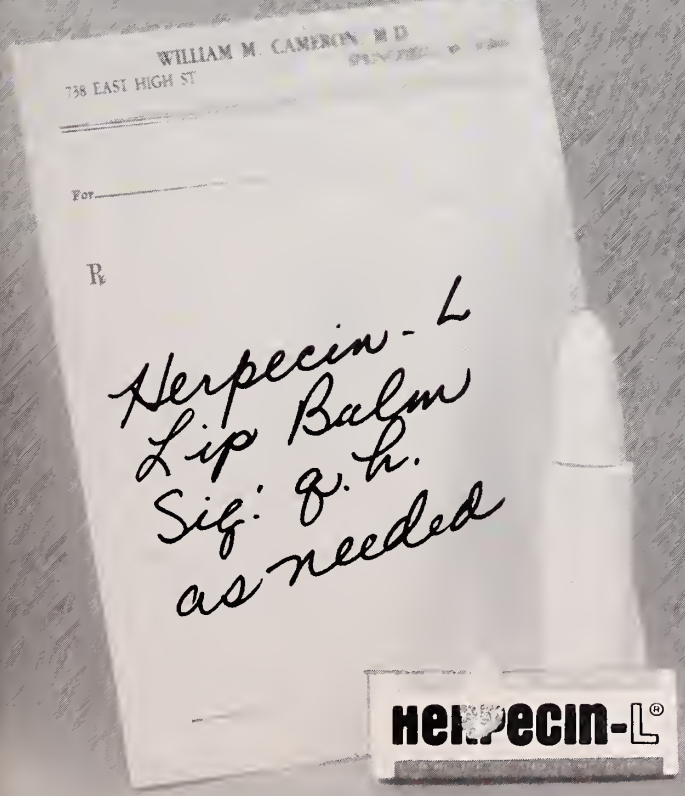


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**Contraindication:** Keflet is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN SENSITIVE PATIENTS.

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Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile*. Other causes of colitis should be ruled out.

*Usage in Pregnancy*—Safety of this product for use during pregnancy has not been established.

**Precautions:** *General*—Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflet may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Keflet should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

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Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

*Usage in Pregnancy—Pregnancy Category B*—The daily oral administration of cephalexin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalexin during pregnancy in humans has not been established.

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**Adverse Reactions:** *Gastrointestinal*—Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

*Hypersensitivity*—Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Reversible interstitial nephritis has been reported rarely. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported.

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"Living in the city is lonely enough... with herpes it's like solitary confinement."
ZOVIRAX®
(acyclovir)
CAPSULES
Prevent genital herpes recurrences month after month with daily therapy.
(In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.)
Please see last page of this advertisement for brief summary of prescribing information.

# ZOVIRAX® (acyclovir) CAPSULES

# Help free your patients from recurrences.

## Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks —month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

## Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

## Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

*Please see brief summary of prescribing information on next page.*

# Prevent recurrences month after month*

# ZOVIRAX® (acyclovir) CAPSULES

Brief Summary

**INDICATIONS AND USAGE:** Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psycho-social difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

**First Episodes** (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

**Recurrent Episodes:**

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

**CONTRAINDICATIONS:** Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

**WARNINGS:** Zovirax Capsules are intended for oral ingestion only.

**PRECAUTIONS: General:** Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

**Drug Interactions:** Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the $F_1$ generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

**Pregnancy:** ***Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS — Short-Term Administration:** The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

**Long-Term Administration:** The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

**DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes:** One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

**Chronic suppressive therapy for recurrent disease:** One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

**Intermittent Therapy:** One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

**Patients With Acute or Chronic Renal Impairment:** One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance $\leq 10$ ml/min/1.73/m$^2$.

**HOW SUPPLIED:** Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200" - Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

Burroughs Wellcome Co., Research Triangle Park, North Carolina 27709

IMPROVING LIVES THROUGH ANTIVIRAL RESEARCH

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# Congenital Hypoplasia of the Left Anterior Descending Coronary Artery Simulating Myocardial Ischemia

*Syed H. Shirazi, M.D., Byron R. Williams, Jr., M.D.*


## ABSTRACT

*This report describes a case of congenital hypoplasia of the left anterior descending coronary artery in a 36-year-old woman who presented with left arm pain and numbness. Electrocardiogram showed left axis deviation and T wave inversion in the precordial leads. Non-invasive studies failed to reveal evidence of ischemic or left ventricular dysfunction. The patient is doing well at 5 years follow-up. Review of the literature suggests that this anomaly is benign and hemodynamically insignificant.*


## Introduction

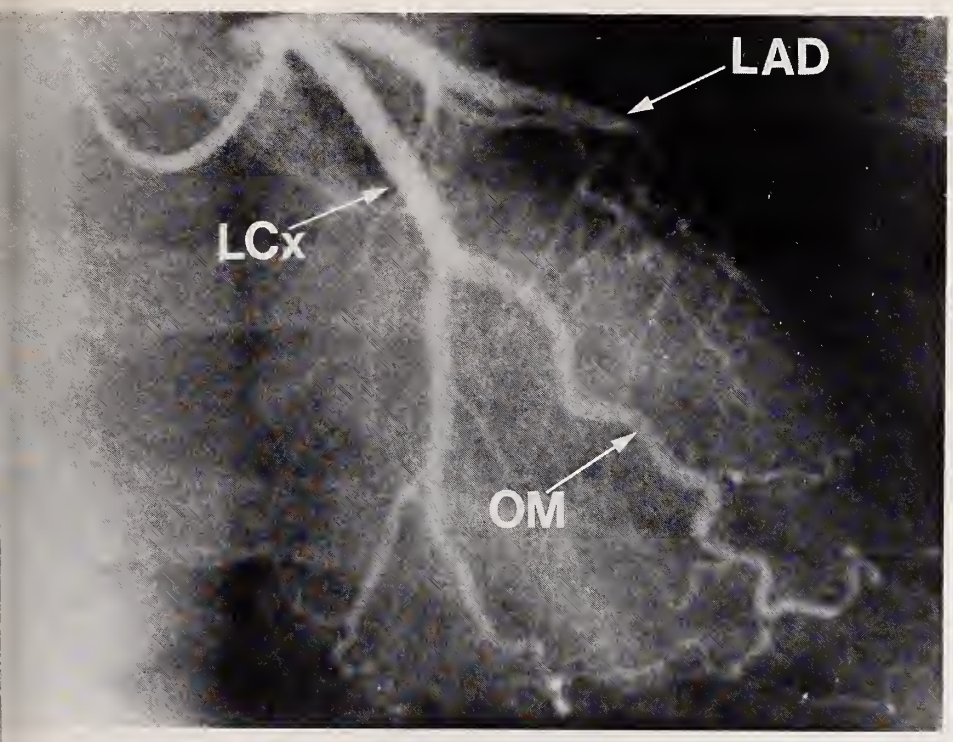
LEVIN, ET AL.[1] classified the primary congenital anomalies of the coronary arteries (isolated anomalies without other congenital heart disease) into hemodynamically significant and insignificant, based on myocardial perfusion. The hemodynamically significant anomalies are characterized by altered myocardial perfusion and are of four major types: 1) coronary fistulae; 2) origin of the left coronary artery (LCA) from the pulmonary artery (PA); 3) congenital coronary stenosis or atresia; and 4) origin of the LCA from the right sinus of Valsalva, with subsequent passage of the vessel between the aorta and right ventricular infundibulum. The hemodynamically insignificant coronary artery anomalies have normal myocardial perfusion and include abnormal aortic origin, size, course, and distribution. They occur in slightly less than 1% of adult patients undergoing coronary arteriography. The purpose of this report is to describe a congenital anomaly of the coronary artery with abnormal distribution but normal myocardial perfusion,[1] which at initial presentation simulated myocardial ischemia.

From the Department of Cardiology, St. Joseph's Hospital, Atlanta. Send reprint requests to Dr. Shirazi, 4555-N Challowford Medical Center, Atlanta, GA 30338.

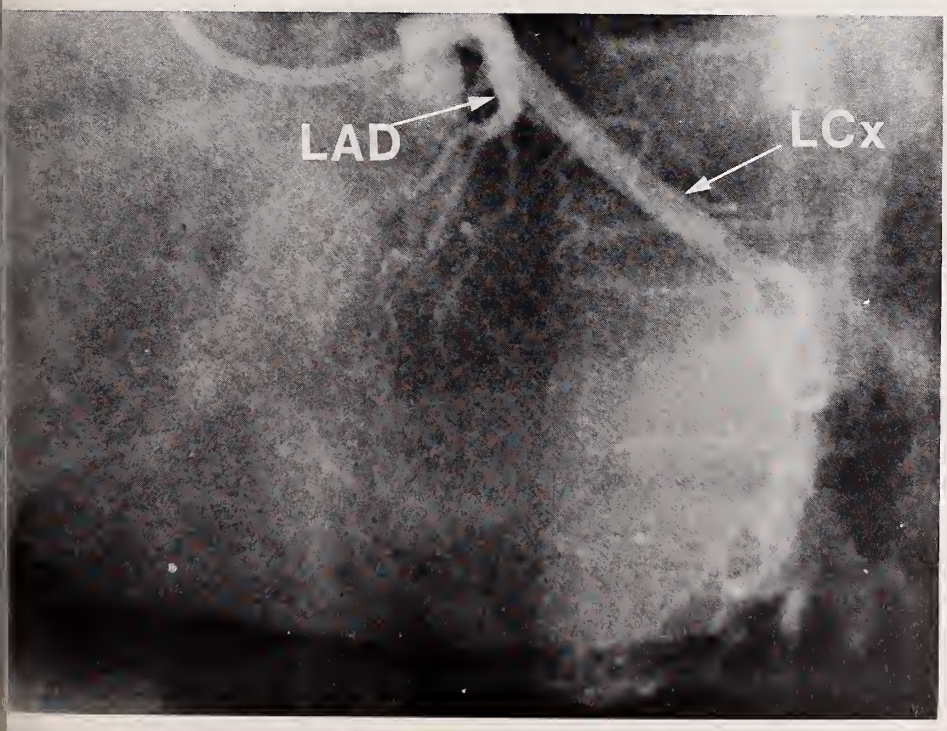
## Case Report

A 36-year-old white, moderately obese woman was admitted to the Coronary Care Unit of a community hospital in February 1981, with left arm pain and numbness of 10 hours duration. The pain was dull, non-pleuritic, and non-exertional. The patient had been in good health prior to this episode. There was no history of shortness of breath, palpitations, syncope, heart attack, diabetes, or hypertension. The patient denied cigarette smoking or alcohol consumption. Her mother died of a heart attack at the age of 56 and her father of a stroke at 68. There was no family history of sudden death at a young age.

*Physical examination:* Blood pressure measured 140/90. Cardiac examination revealed S4, otherwise normal. Chest X-ray, routine hematologic profile, serum chemistries, and cardiac enzymes were normal. Admission ECG (Figure 1) revealed normal sinus rhythm at 80 bpm with occasional premature ventricular beats, left axis deviation with T wave inversion in precordial leads $V_1$-$V_4$ compatible with anterior wall ischemia, juvenile T-waves, or subendocardial infarction. Echocardiogram revealed normal left ventricular contractility without evidence of mitral valve prolapse, asymmetrical septal hypertrophy or pericardial effusion. Ventilation and perfusion lung scans were normal. Coronary angiogram and left ventriculogram were done because of unexplained symptoms and ECG abnormalities.




*igure 2: The left coronary artery in RAO projection, LAD = left anterior de-nding, OM = obtuse marginal branch, LCx = left circumflex.*




*igure 3: The left coronary artery in LAO projection (45). LAD = left anterior cending, LCx = left circumflex, OM = obtuse marginal branch.*

Cine coronary arteriogram (Figures 2 and 3) revealed a congenitally short left anterior descending coronary artery, which extended up to the proximal one-third of the anterolateral wall, after giving off the first septal perforator and then tapering into multiple small caliber diagonal and septal perforator branches reaching almost two-thirds of the anterolateral wall. The distal one-third of the anterolateral wall and apical portion of the left ventricle were supplied by the large obtuse marginal branch of the circumflex and via right ventricular and posterior descending branches of the right coronary artery. All three coronary arteries were free of significant luminal narrowing. The left ventriculogram revealed a normal size left ventricle with normal contractility and without evidence of mitral valve prolapse or hypertrophic cardiomyopathy. An exercise Thallium study was done to assess myocardial perfusion abnormality in the anterolateral and apical portions of the left ventricle, as possible explanation of the T-wave changes on ECG. The patient completed 1 minute of the stage IV of the Bruce protocol with a total exercise time of 10 minutes. T wave inversion in the precordial leads, $V_1$ through $V_4$, became upright at 6 minutes and returned to the inverted state at rest.[4] Myocardial perfusion was normal. The patient continued to have intermittent left arm pain, but in view of the normal Thallium study and left ventricular function, she was reassured that her pain was non-cardiac, and no treatment was given. At 5 years follow-up, she has occasional left arm pain, ECG changes persist, but her exercise Thallium study and

exercise radionuclide ventriculogram remain normal without objective evidence of ischemia. The only new finding is a lipid abnormality (Triglycerides: 340, cholesterol: 257).

### Discussion

Congenital hypoplasia of the left anterior descending (LAD) coronary artery is exceedingly rare. Only a few cases have been described in the literature.[3-6, 11] Right coronary artery (RCA) hypoplasia is more common than left.[3, 7] Alexander, et al., in 18,950 autopsies over a period of 10 years,

***"The patient presented with left arm pain and numbness of 10 hours duration. The pain was dull, non-pleuritic, and non-exertional."***

found only six cases of hypoplasia of the coronary arteries. Of those six cases, four were small RCA and two were small circumflex (Cx).

The usual mode of presentation is atypical chest pain or angina.[3, 6] Some patients are asymptomatic, with the discovery being an incidental autopsy finding.[8] With a hypoplastic coronary artery, the myocardium usually supplied by this (hypoplastic) artery is perfused via branches from the other coronary arteries, so the circulation is usually balanced.[4] Hence, these anomalies are functionally and prognostically insignificant in the absence of other disease.[2-4, 7] Grossman, et al.[3] described four cases of hypoplasia of the coronary arteries. All were young patients below 35 years of age who presented with chest pain or palpitations. All these patients improved with supportive treatment. Ferguson, et al.[2] described a 30-year-old woman with absent left anterior descending coronary artery and anomalous origin of the circumfle from the right coronary artery. The patient presented with chest pain and intermittent left bundle branc block. ECG revealed T wave

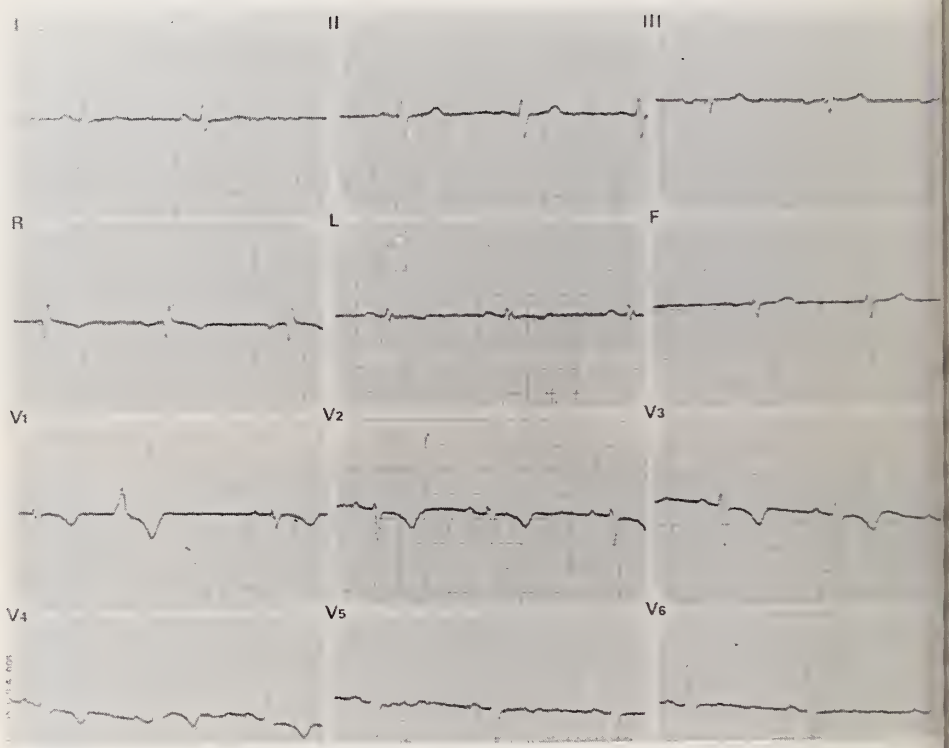



*Figure 1: Resting electrocardiogram demonstrating abnormal left axis deviation and T-wave inversions in precordial leads $V_1$-$V_4$.*

ersion in leads $V_1$-$V_3$. Thallium d radionuclide studies were rmal, suggesting a benign nical course and prognosis. odaver, et al.[4] described a 44-ar-old man with hypoplasia of e LAD. The patient presented th atypical chest pain, type IV perlipidemia, and non-specific -T changes. Chest pain was nsidered non-cardiac in origin. In addition to these cases with a emingly benign course, there are se reports of patients with poplasia of the coronary arteries th significant clinical problems ch as sudden death, heart lure, arrhythmia, and myocardial arction.[3, 9-11] Blake, et al.[10]

***"Primary congenital nomalies of the oronary arteries have een classified into emodynamically gnificant and nsignificant, based on yocardial erfusion."***

escribed a 20-year-old basketball ayer with hypoplasia of the RCA no died suddenly, possibly due to ronary insufficiency. Kjaergaard, al.[9] described a 36-year-old oman with hypoplasia of the Cx nd corresponding left ventricular all motion abnormality who died ddenly. Hillestad, et al.[6] escribed two patients with poplasia of the RCA and LCA ho sustained posterior and nterolateral myocardial infarctions, respectively. Wenger, et al.[11] reported a 2-day-old baby with complete left bundle branch and absent atrial activity, who at autopsy was found to have rudimentary LCA. Grossman, et al.[3] described three more patients with hypoplasia of the coronary arteries who sustained myocardial infarction. In one case, the LAD was absent, and in another, the LAD was hypoplastic and occluded in its proximal one centimeter. The third case had hypoplastic LAD and Cx. This discrepancy in clinical course and prognosis in hypoplastic coronary arteries is not fully understood. We believe this variability may be due to impaired myocardial perfusion, responsible for myocardial injury,[11] perhaps caused by additional atherosclerotic disease,[4] abnormal vasomotor tone,[5] or uncompensated perfusion from the branches of other arteries.

In our patient, the interesting ECG finding was left axis deviation and T wave inversion in precordial leads $V_1$-$V_4$.[3, 4] We initially considered that her ECG changes were caused by the congenitally short LAD causing insufficient perfusion to the anterolateral wall and apical portion of the left ventricle. The normal exercise Thallium scan and preserved left ventricular contractility failed to support our view. Hence, we considered that the ECG changes may not represent ischemia, as described by Taggart, et al.[12] in individuals with normal coronary arteries, due to altered beta adrenergic responsiveness, or these may represent persistent juvenile pattern.[13]

In the absence of objective evidence of functionally significant myocardial ischemia or impaired perfusion, patients with hypoplastic coronary arteries appear to have a benign clinical course, such as that seen with our patient. We suggest, after the diagnosis of congenital hypoplasia of the coronary arteries is established by coronary angiography functional studies, such as exercise Thallium and rest/exercise, radionuclide ventriculography should be done to better define the hemodynamic significance, manageament,[5] and long-term prognosis in these patients.

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# Mammography in Atlanta

*Wong-Ho Chow, Ph.D., Jonathan M. Liff, Ph.D., Raymond S. Greenberg, M.D., Ph.D.*


## ABSTRACT

ALL MAMMOGRAPHY *facilities in five counties of metropolitan Atlanta were surveyed to evaluate trends in the use of this technology. Of 33 identified diagnostic centers, 32 (97%) responded to this inquiry. During the years 1983 through 1986, the estimated total number of examinations reported was 174,000. The annual number of mammograms increased from 19,800 in 1983 to 70,500 in 1986. Overall, about two-thirds of examinations were performed at hospital-based units, but a trend toward use by free-standing diagnostic centers was observed.*


## Introduction

Several health organizations, including the American Cancer Society,[1] the American Medical Association,[2] and the American College of Physicians,[3] have recommended routine mammographic screening for breast cancer among asymptomatic women aged 50 or older. There is evidence, however, that many women in the United States are not in compliance with these guidelines. For example, a national poll conducted during 1983 revealed that less than 40% of adult women had ever had a mammogram.[4] Among those respondents aged 50 or older, less than one-sixth indicated that they underwent annual mammographic examinations.

At the present time, there is little information available on the volume of mammographic screening within specific communities. In an effort to collect such information for Atlanta, a survey of mammographic facilities was conducted. The results of that survey are described in this article.

## Methods

The Radiology Department of every hospital in five counties of metropolitan Atlanta (Clayton, Cobb, DeKalb, Fulton, and Gwinnett) was contacted in April, 1987, to determine whether mammograms were performed at that facility. In addition, these Departments were requested to identify any known free-standing mammography centers. Through this process, 33 separate active facilities were identified. Each diagnostic center was contacted b letter and requested to complete a brief questionnaire on the annual number of mammograms performed during each of the yea between 1983 and 1986. If a response was not received from a facility, repeat telephone and written inquiries were made. Of a contacted diagnostic units, 32 (97%) provided a response.

Of the 32 responding facilities, 24 (75%) had known annual numbers of examinations for eac year of the study period. Of these 24 centers, 12 had been in operation for all 4 years of the study, an additional three were active for 3 years, another seven f 2 years, and two for 1 year. Of th remaining eight responding facilities, five had known number of annual examinations for at lea part of the study period, and only three units (9%) could not provid any estimates of annual examinations.

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Send reprint requests to Dr. Greenberg, Georgia Center for Cancer Statistics, 246 Sycamore St., Ste. 100, Decatur, GA 30030.

The responses from all facilities ere aggregated to obtain overall nual numbers of examinations. ese responses also were atified by location of facility ospital versus other).

### Results

The total number of aminations performed during this ear period was approximately 4,000. As shown in Figure 1, the nual number of mammograms creased dramatically during the dy period. The number of aminations performed during 86 was more than three times e corresponding number for 83. The percentage increase was t uniform over this study period, th the greatest proportionate rise 7%) between 1984 and 1985. The nual number of examinations at dividual facilities ranged between 0 and 10,842. The mean number examinations per reporting cility with complete information s 1,651 during 1983 and creased progressively to 2,937 ring 1986.

When the data were analyzed by cation of facility, it was found at hospital-based units accounted more than two-thirds of all aminations (Figure 2). Over the urse of the study period, wever, a shift was observed in the proportion of examinations performed at free-standing centers. In 1983, only 14% of mammograms were obtained at free-standing centers, whereas these facilities accounted for 33% of all mammograms performed in 1986.

An attempt was made to estimate the percentage of all mammograms that were obtained for asymptomatic women. Many facilities, however, did not have summary information on whether examinees had symptoms. Approximately half of the respondents supplied estimates of the percentage of examinations that were performed on asymptomatic women. These estimates ranged from 15% (at two public hospitals) to 95% (at a private, free-standing center), with most responses falling between 60 and 90%. The estimated annual percentages of asymptomatic examinees increased over time at virtually all of the facilities that provided this type of information.

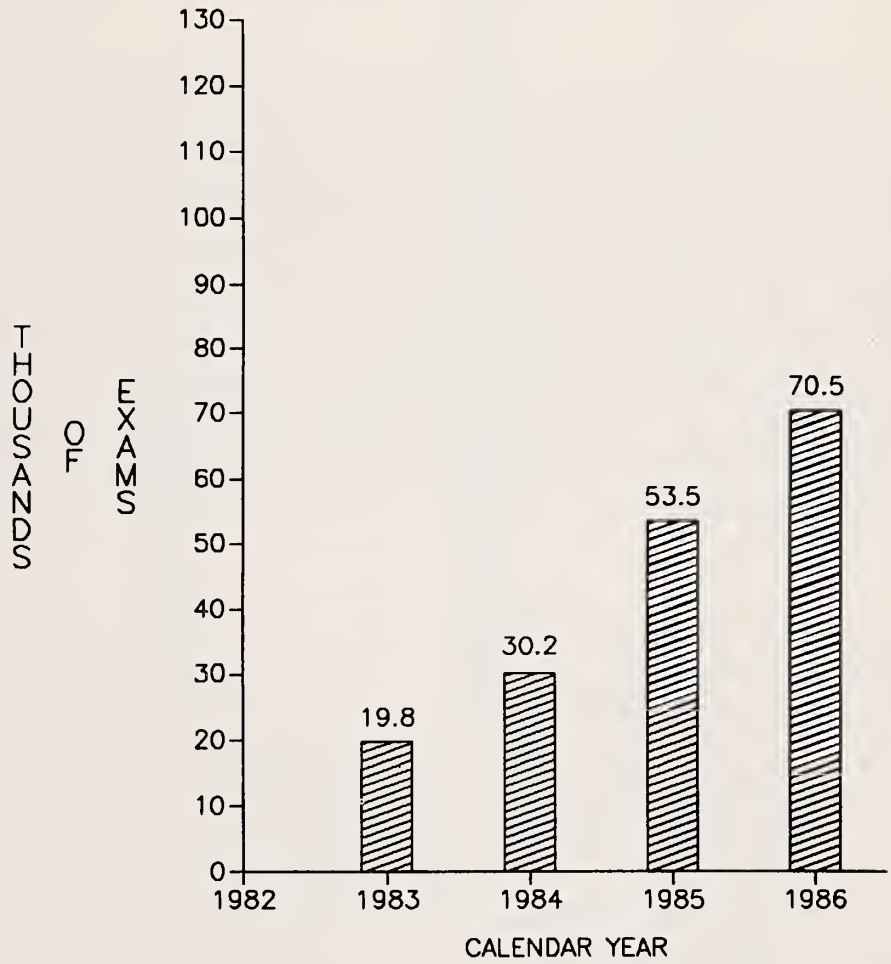


Figure 1. Number of Mammographic Exams in Atlanta, by Calendar Year

### Discussion

Although the findings of this survey provided encouraging evidence that the use of mammography in Atlanta has increased in recent years, it cannot

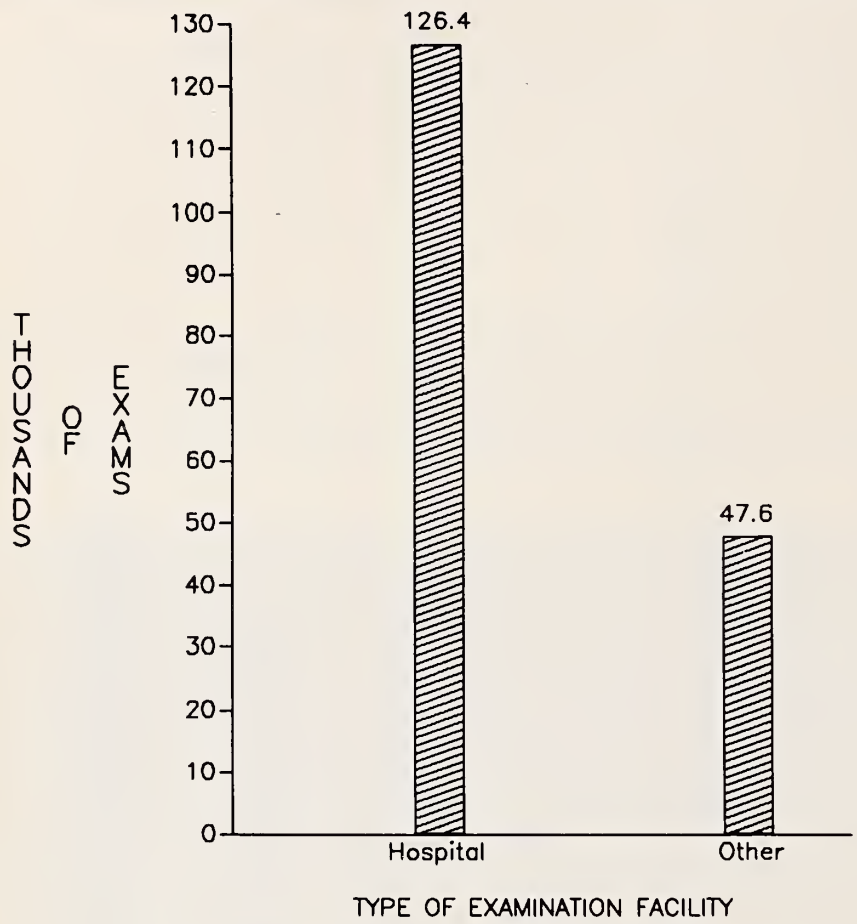


Figure 2. Number of Mammographic Exams in Atlanta, by Type of Facility, 1983 – 1986.

be inferred from these data that an acceptable level of screening has been achieved. The present information is limited in several respects, perhaps most importantly in its inability to provide information about the proportion of mammographic examinations that were performed for screening purposes. Among those facilities reporting estimated proportions of asymptomatic examinees, a fairly wide range of responses was obtained. Those facilities with low fractions of asymptomatic women tended to be at public institutions serving low-income populations. In contrast, facilities with high levels of asymptomatic examinees tended to be private units serving a middle and upper-income clientele. The wide variation in the proportions of asymptomatic women screened, combined with the absence of this information from about half of the facilities, makes it difficult to estimate this proportion for the entire metropolitan area.

The present data are limited further by a lack of information on the age distribution of examinees and the number of women who underwent multiple examinations. It also is possible that growth in the population of Atlanta and expansion of the referral areas of these facilities could account for part of the observed increase in the volume of examinations. With such constraints in mind, it is clear that this survey can describe only the broadest outlines of mammographic screening practices in Atlanta.

Writing in an earlier issue of the *Journal*, Huguley[5] emphasized that mammography is the most effective technique for detecting breast cancer at an early stage. That conclusion is supported by the results of large, randomized controlled trials of the efficacy of mammography. The first and still most persuasive demonstration of the benefits of mammography was obtained in a study conducted by the Health Insurance Plan (HIP) of New York.[6] In that trial, 62,000 women were randomized into two groups; half of the subjects were offered annual mammography and breast palpation and the other half received their usual care. For women aged 50 or older at entry, the 10-year mortality from breast cancer was one-third lower among screenees than among controls.

The preliminary results of a randomized controlled trial in Sweden[7] provided evidence that mammography alone can decrease mortality from breast cancer. In that investigation, mammographic screening at 3-year intervals produced a 40% reduction in breast cancer mortality for women between the ages of 50 and 74.

In spite of the repeated demonstrations that screening mammography can prevent deaths from breast cancer, many physicians are still reluctant to advise asymptomatic women to obtain these exagminations. A survey of family physicians in New York State that was conducted during 1981 revealed that only 8% of respondents recommended annual mammographic screening to their female patients aged 50 or older.[8] Four out of 10 respondents were concerned that radiation from the mammography might increase

e risk of breast cancer. A third of mily physicians indicated that ey felt screening of asymptomatic omen resulted in a low yield of tected cancers. More than 20% surveyed physicians questioned e reliability of mammography and similar percentage believed that e cost of mammography was too pensive for screening purposes.

***"Although the findings f this survey provided ncouraging evidence that e use of mammography Atlanta has increased recent years, it cannot e inferred from these ata that an acceptable vel of screening has een achieved."***

In fact, deleterious radiogenic ects of mammograms should be minimal concern to physicians day, when balanced against the nefits of early mammographic tection. Based on average diation dosages used in ammography 10 years ago, it was timated that less than 1% of east cancers detected among nually screened women aged 50 older would be attributable to diation from the mammograms.[9] is equates to a ratio of 10 lives ved through early detection for ery cancer caused by ammography. With progressive duction in the doses of radiation ed in mammography, the benefit-to-cost ratio is even more favorable today.

Of equal importance is the financial burden of these examinations on screened women. The average cost of bilateral mammography was not assessed in the present study, but a recent informal survey conducted by the Georgia Division of the American Cancer Society indicated that typical costs for routine mammographic screening varied widely, from $70 to $200 per examination. Since the costs of mammography often are not reimbursed by insurance providers, the charges for this screening are borne as out-of-pocket expenses for most women. A recent low cost ($50) mammography project in Atlanta sponsored by the American Cancer Society suggested that when the price barrier is diminished many women will obtain mammograms.

Breast cancer is the most common malignancy among women in the United States, accounting for an estimated 2,400 new cancers in Georgia in 1987.[10] It also is the second leading cause of death from cancer among women.

**TABLE 1 — American Cancer Society Guidelines for Mammographic Screening of Asymptomatic Women**

| *Age (years)* | *Recommendation* |
|---|---|
| 35-39 | Baseline mammogram |
| 40-49 | Mammogram every 1 to 2 years |
| ≥ 50 | Mammogram every year |

***"In spite of the repeated demonstrations that screening mammography can prevent deaths from breast cancer, many physicians are still reluctant to advise asymptomatic women to obtain these examinations."***

Fortunately, the morbidity and mortality of this disease can be reduced dramatically if it is diagnosed at an early stage. The importance of the physician's role in screening is underscored by a Los Angeles survey in which 93% of 530 women responded that they would obtain a mammogram if it were recommended by a physician.[11]

The American Cancer Society guidelines for mammographic screening of asymptomatic women are shown in Table 1.[12] These

guidelines are based upon considerable evaluation and represent a standard toward which all patients and physicians should strive.

***"The importance of the physician's role in screening is underscored by a Los Angeles survey in which 93% of 530 women responded that they would obtain a mammogram if it were recommended by a physician."***


### Acknowledgments

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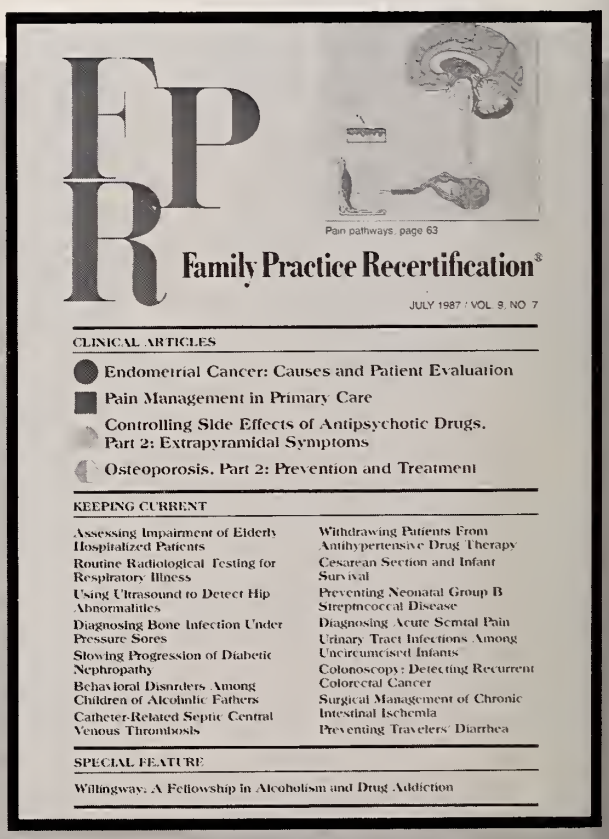
FPR
Pain pathways, page 63
Family Practice Recertification®
JULY 1987 / VOL 9, NO 7
CLINICAL ARTICLES
Endometrial Cancer: Causes and Patient Evaluation
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KEEPING CURRENT
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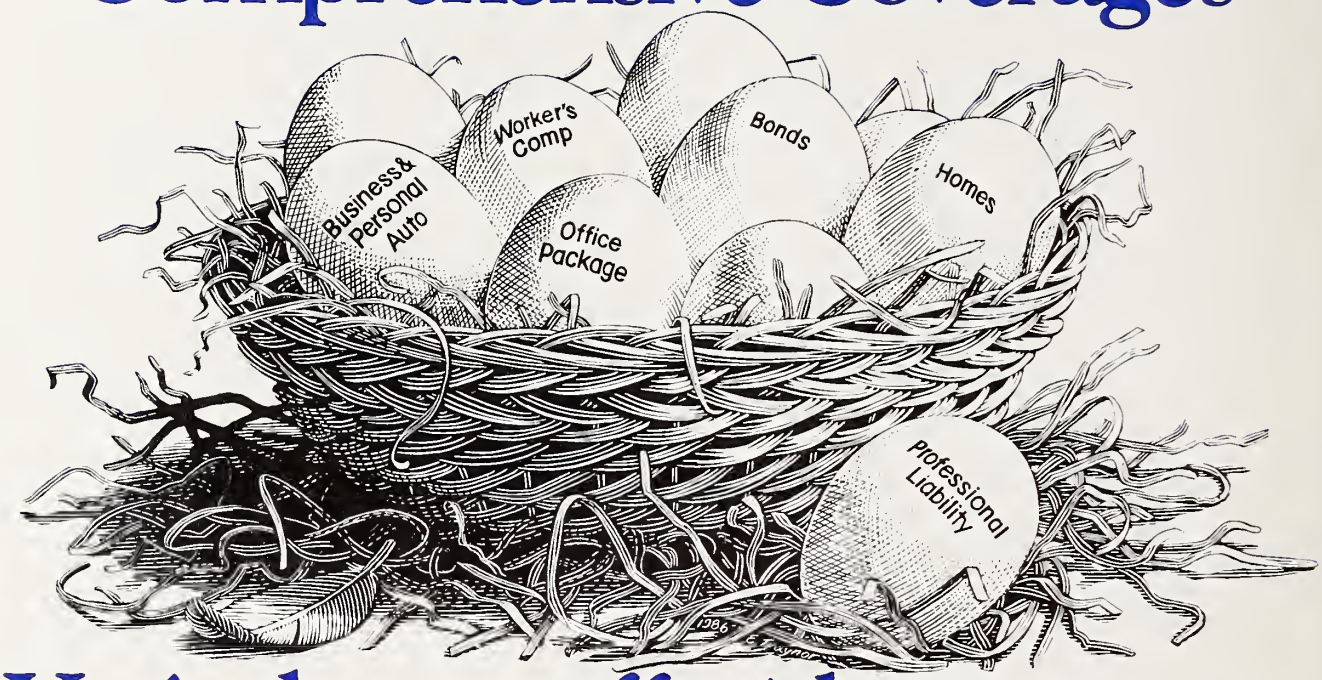


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# CONTENTS VOLUME 76, NUMBER 12

## FEATURES

MAG LEADERSHIP CONFERENCE, 1988 818

DEMOGRAPHICS OF ATLANTA'S HOMICIDE EPICENTER: 1984 825
By Randy Hanzlick, M.D., F.A.C.P., Diane Jarret, M.D., George Birdsong, M.D.

ADOLESCENT URINE DRUG SCREENING: A Cobb County Medical Society Program 833
By Dirk E. Huttenbach, M.D.

POSTSTREPTOCOCCAL ACUTE GLOMERULONEPHRITIS IN EARLY COUNTY, 1982 839
By Alan B. Bloch, M.D., M.P.H., J. David Smith, B.S., Richard R. Facklam, Ph.D., Thomas W. McKinley, M.P.H., R. Keith Sikes, D.V.M., M.P.H.

AMBULANCE SERVICES IN GEORGIA 1982-1985 845
By Thomas W. McKinley, M.P.H., R. Keith Sikes, D.V.M., M.P.H., Dallas P. Jankowski, J.D.

ANNUAL JOURNAL INDEX 858

## EDITORIAL

PHYSICIANS — PART OF THE COMMUNITY, TOO 813
By Vickie Skandalakis Scaljon, M.A., John E. Skandalakis, M.D., Ph.D., F.A.C.S., Stephen W. Gray, Ph.D.

## CANCER

LOCALLY ADVANCED CARCINOMA OF THE BREAST 852
By Erich G. Randolph, M.D.

## HEART

NEW INOTROPIC DRUGS: AMRINONE AND MILRINONE 854
By Jimmy V. Lemke, B.S., M.B.A., SC(ASCP)

## DEPARTMENTS

ABOUT THE COVER ARTIST: RON RANSOM 801

A COINCIDENCE 802

EDITOR'S CORNER 803

LETTERS TO THE EDITOR 806

PRESIDENT'S PAGE 807

ASSOCIATION NEWS 808

CALENDAR 812

THE MONEY OF POLITIC$ 817

INDEX TO ADVERTISING/MANUSCRIPT INFORMATION 864

## COVER

Featured on this month's cover are Santa carvings by Ron Ransom. Read about this man-of-many-talents and his art on page 801. (And lest you think this cover "too Christian," read Dr. Underwood's remarks on page 803.)
Cover photograph by Luis Bigit, of Rogers and Bigit, Atlanta.

## PHYSICIANS, SCHEDULE SOME TIME FOR YOUR COUNTRY.

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## About the Cover Artist:

# Ron Ransom

THE VARIETY OF CARVED SANTAS pictured on this month's cover is a reflection of the talent of the wood carver. Ron Ransom, a well known carver, also teaches classes and has recently published a how-to book entitled *Santa Carving.* He has been featured in "Inside Cobb" magazine, and in 1986, a counted cross-stitch book publisher used his Santas on the cover of their "Back Home Christmas" stitchery book. A cartoonist as well, his "Thumbprints" appears regularly in the *Marietta Daily Journal,* and the clever mouse cartoon has been artfully captured in a booklet called *Thumbs Up!* as well as in cross-stitch designs by a local graphics company.

Mr. Ransom's musical talent is expressed in a rich baritone voice; he is a frequent soloist. He says his interest in the arts is probably inherited from his grandfather, Nicholas Ransom, a circus clown and ventriloquist, and from his father, a versatile musician.

Mr. Ransom is also the Director of Parks and Recreation for the City of Marietta, Georgia. Enjoying the revival of the art of wood carving, he also carves birds and decoys, though the Santas now occupy most of his carving time. His work is available at Back Home Antiques, 1460 Roswell Rd., Marietta, GA 30062; 404-971-5342.

His Santas, symbolic of all that is good, is a constant reminder of things eternal. It is fitting that such a symbol be featured on the cover of our December issue. Perhaps this is more clearly stated in the excerpt from the 1897 editorial in the *New York Sun:*

> *"Yes, Virginia, there is a Santa Claus. He exists as certainly as love and generosity and devotion exist, and you know that they abound and give to your life its highest beauty and joy. Alas! How dreary would be the world if there were no Santa Claus."*

# A COINCIDENCE

**Robert M. Webster, M.D.**

It was Friday night. The Emory University Medical Library was quieter than usual. It was between terms on a beautiful summer evening in Atlanta. The Dog Days sun had set fiery red, the air was still with a high humidity, but the library air, temperature and humidity controlled, was chilly as it blew through the ventilation ducts. I was reviewing the literature to prepare for the examinations of the Conjoint Board of Allergy and Immunology. Three or four other "scholars" were doing their library projects.

***"It was between terms on a eautiful summer evening in tlanta. The Dog Days sun had set ery red, the air was still with a igh humidity. . . ."***

The library silence and the shush of the air flow prevailed. But from time to time, from a cubicle down the aisle came irregular bursts of a soft staccato sound. I was curious. There would be silence, then this run of staccato sounds. Not the sound of a copier, or an adding machine, not morse code or a classical typewriter sound — what could it be? A library cart piled high with books and journals was down the aisle at that cubicle. Several times I had the urge to check the cause, but I did not want to intrude or interrupt my own studies.

Suddenly an irrestible compulsion overtook me. Some Force within said, "Check it out! investigate! Now!! Right now!!!" So I did.

In the cubicle, open and closed books and journals were scattered all over the counter. On top was a thin, portable, battery-operated Brothers typewriter. So *that* was the cause of those soft, stacatto sounds, made by this scholar. There was a professor of pediatrics researching the literature for articles and data on spider bites and typing his notes.

***"But from time to time, fro cubicle down the aisle came irregular bursts of a soft stacc sound. I was curious."***

The topmost journal in the assorted collection suddenly caught my eye. There, in that journal was *my* photograph of a spider bite in one of *my* patients! It was one of the pictures used in an article on spider bites published by Dr. Butz,[1] formerly pathologist at Fort MacPherson. I had given Dr. Butts a series of photos taken over a 10-day period when I had treated apatient for a spider bite on the calf of her leg. The photos showed the evolution of the healing under my treatment. I was struck by the nature of the coincidence — about walking into that cubicle at *the* moment the researcher was looking at the photo of *my* patient.

Of course, he and I discussed the coincidence, the bite, its progress, my treatment, and spider bites in general. We had a pleasant conversation. We had met like ships that pass in the night. We parted, our paths not likely to cross again.

One could ask how or why such a coincidence occurred. An astute colleague remarked, "Of inquiring-minded persons the scientist asks 'What?' the philosopher asks 'Why?' "

Dr. Webster specializes in internal medicine/allergy. Send reprint requests to him at 2665 Acadia St., East Point, GA 30344.

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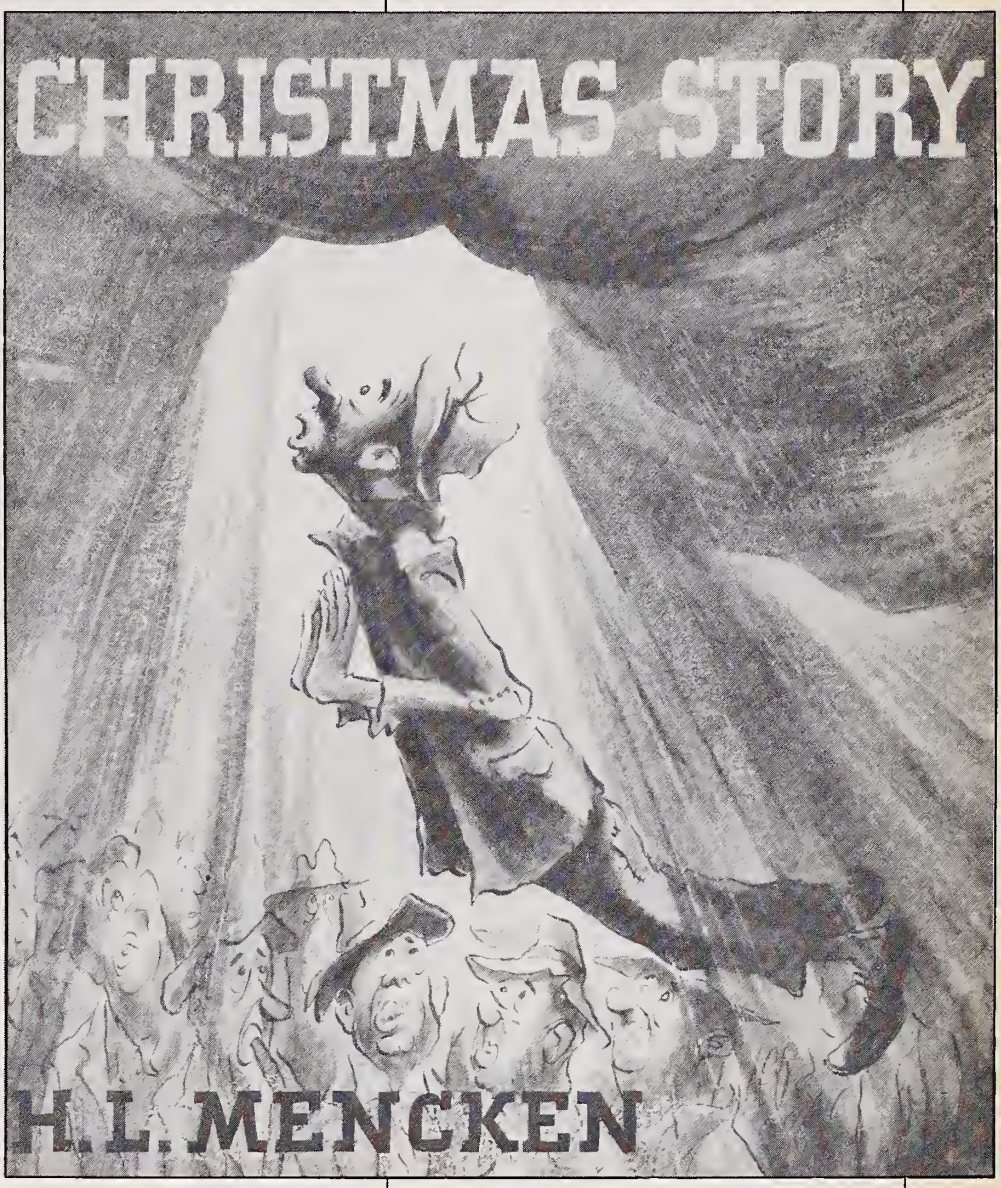


'DON'T MAKE IT TOO CHRISTIAN," she had said me. We were talking, the anaging editor and I, about "The litor's Corner" for this issue of e Journal. And so I thought, ometimes that may be the oblem — the problem for all of , be we Jewish, Turkish, Mormon , as was H. L. Mencken, just a bit nostic — or surely, be we ıristian.'" Perhaps it even carried er into the rest of the days of our es, the matter of trying to be mething that we really weren't. ıd so it seemed easy to lose the ıl heart of Christmas, the getting of self and the doing for ıers, that make the season mething more than a round of ice parties.

ut back to Mencken. He was born in Baltimore in 1886 and ed there in 1956. Most of that ıe he wrote for the *Baltimore n* papers, becoming during that ıe one of the master craftsmen the journalistic trade, writing ustic editorials for those papers, iting books, and in general ncturing some of the balloons of de and egotism that floated ɔund the country. It was in 1946 ıt he wrote *Christmas Story,* his ortest book and in the quasi nosticism in which he lived, rhaps knew that he was saying mething about the Christmas ason that he would not care for e to recognize as soft or ntimental.

t is the story of Fred Ammermeyer as he and one of Baltimore wharf front licemen decided upon and nned a Christmas banquet for "bums" the "wharf rats," of the ltimore waterfront. Mencken had horred the usual givers of such nquets, the W.C.T.U. and the ıurch ladies," who harangued "bums" with views of a heavenly peace if they would only give up their ways. And so it was that Fred and his policeman friend decided upon those to be invited to the banquet.

> *"No bum who had ever been known to do any honest work, even such light work as sweeping out a saloon, was on the list. By Fred's express and oft-repeated command, it was made up wholly of men completely lost to human decency, in whose favor nothing whatsoever could be said."*

***"In all of Mencken's callous and calculated toughness, he seemed to let* Christmas Story *stand as a small window for us to look through and see that there was a softness inside that had full cognizance of the sometimes sad plight of our race."***

Careful attention was given to the matters of food and entertainment that would seem to provide the most satisfying experience for the invited guests:

*"First and foremost, they wanted as much malt liquor as they would buy themselves if they had the means to buy it. Second, they wanted a dinner that went on in rhythmic waves, all day and all night, until the hungriest and hollowest bum was reduced to breathing with not more than one cylinder of one lung. Third, they wanted not a mere sufficiency but a riotous superfluity of the best five-cent cigars on sale on the Baltimore wharves. Fourth, they wanted continuous entertainment, both theatrical and musical, of a sort in consonance with their natural tastes and their station in life. Fifth and last, they wanted complete freedom from evangelical harassment of whatever sort, before, during, and after the secular ceremonies."*

The gluttonous encounter wore on through the afternoon and evening:

*"The show continued at high tempo until 2 P.M., when Fred shut it down to give his guests a chance to eat the second canto of their dinner. It was a duplicate of the first in every detail, with second and third helpings of turkey, sauerkraut, mashed potatoes, and celery for everyone who called for them, and a pitcher of beer in front of each guest. The boys ground away at it for an hour, and then lit fresh cigars and leaned back comfortably for the second part of the show. It was still basically 'Krausmeyer's Alley,' but it was a 'Krausmeyer's Alley' adorned and bedizened with reminiscences of every other burlesque-show curtain raiser and afterpiece in the repertory. It went on and on for four solid hours, with Larry and his pals bending themselves to their utmost exertions, and the girls shaking their legs in almost frantic abandon."*

There is a pathos in this story, sadness for men down on the luck or down on their ambition. There is also a ray of hope for it describes someone interested in and willing to do something abou the apparent hopelessness of the situation. In all of Mencken's callous and calculated toughness, he seemed to let *Christmas Story* stand as a small window for us to look through and see that there was a softness inside that had ful cognizance of the sometimes sad plight of our race. He seemed to me to be saying that we sometime have to get away from being "too Christian" to find the real heart of Christmas. ■

*Charles R. Underwood, M.D.*

# How More Than 3000 Doctors Have Eased The Pain Of Managing A Practice.

If your practice is like a lot of others, you often spend more time on office problems than on the health problems of your patients.

Our one easy-to-use, fully-integrated computer system can take care of billing, provide financial updates, help you market your practice. And give you more time to do what you went to medical school for.

**"We've found that Medic saves us many hours of paperwork every week. A couple of hours of work is down to 15 minutes."**
*Jeanine Mielke, office manager, Hahn, Hoard & Taub, M.D., P.A., Boca Raton, Florida*

This urology practice uses Medic Computer Systems to electronically transmit many Medicare claims every day. A job that once took a large part of the business day is now done in minutes. And that's only one of the ways that Medic saves time on paperwork.

**"It's helped our cash flow tremendously."**
*Mike Griga, general manager of Mayfield Neurological Institute, Cincinnati, Ohio*

Changing the billing system from once a month to once a week is just one way Medic has improved the bottom line of the nation's largest neurosurgery group.

**"Any time we've had a problem, Medic has been immediately responsive. They bend over backwards to suit their customers. It's the best money we have ever spent."**
*Wynne Vaughan, office manager, Capital Pediatric and Adolescent Center, P.A., Raleigh, North Carolina*

We'll do whatever it takes to keep your system working. Day or night. We have a toll-free STAT line to handle questions and problems. And there's a STAT PLUS line from our support center to your system for software updates and diagnoses.

**"Our practice has doubled and we have not had to add additional billing personnel. Medic has been able to handle whatever we've asked of it."**
*Nancy Psimas, office coordinator, Portsmouth Orthopaedic Associates, Portsmouth, Virginia*

The Medic system can ease the process of sending statements and reduce the number of uncollected bills. Plus, our easy-to-understand printouts help you keep better track of your financial condition.

**"Medic's extensive training program for our staff made it easy to introduce the system. We recommend it highly."**
*Tessa Horne, administrator, Morgantown Ear, Nose & Throat Clinic, Morgantown, West Virginia*

"We love the training program. And the updates they do really help," Ms. Horne said. When a practice brings in over 200 patients a day as this one does, the business office has to run smoothly. "Medic does everything we need. It's great."

So if you want to increase the efficiency, productivity and profitability of your practice, take a look at the Medic Computer System.

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## Goodbye, Rusty

*Editorial Note: A copy of the following letter addressed to Mr. Rusty Kidd, MAG's former Director of Legislative Activities, was sent to the* Journal *office by Dr. Cohen. After 15 years of dedicated work with the MAG, Rusty resigned last September to pursue other ventures. He is missed. We believe the sentiment expressed in the following letter is shared by many other MAG members and for this reason we are sharing a portion of it with you.*

Dear Rusty,

This letter is somewhat belated. I would want to add my best wishes to you on your stepping forward in your career. I've been a member of many committees and attended many meetings over the last many years and I can say I've observed your many contributions on behalf of MAG. . . .

My purpose for this letter (is) . . . really to thank you for your years of service to our organization and to us as doctors practicing in such a good environment politically. My second purpose is to tell you, I hope my conferees would "hire" your service to continue representing us. You are far too knowledgeable of our problems and far too influential to drop.

For many of my years in the organization, it was always comforting to see you around and involved. I hope it doesn't change too much.

*Your friend,*
*Marvyn D. Cohen, M.D.*
*Pediatrician, Columbus*

**We need you.**

American Heart Association

WE'RE FIGHTING FOR YOUR LIFE

## Caring For The Elderly

Dear Editor:

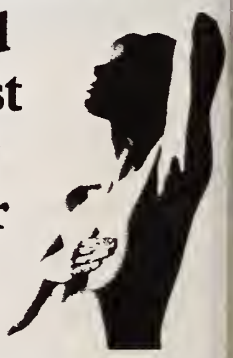
I would like to compliment *JMAG* for your emphasis on the care of the elderly in your September issue. The problems of the aging of our population are a concern which all segments of our society, medical, legislative, civic, and community must address.

One such organization which has addressed these issues for over 20 years is Christian City. Located one mile off I-85 near Union City, Christian City provides a full range of services for the elderly. Beginning 20 years ago with housing for the aged, a complex has developed which includes a nursing home which is one of the few in the state certified by the Joint Commission on Accreditation of Health Care Organizations as being able to provide hospital quality care for residents. In addition, there is 24-hour care as well as day care for Alzheimer patients. The two apartment buildings, 167 life-lease apartments, and nursing home are able to use a recently opened fitness center which offers hydrorobics, a whirlpool with supervision and an exercise room.

In late 1986, Christian City opened its newest link in the care for the elderly with Sparks Tower, a 207 room assisted living facility. Seniors, aged 62 and older, who are not ready for nursing care but can no longer live alone, can enjoy three nourishing meals and a snack each day along with having the housekeeping and laundry done for them. Many amenities are available to residents such as a library, ice-cream parlor, and gift shop as well as a wide range of social, educational, and religious activities. Health services available on campus include regularly scheduled dental clinics, blood pressure clinics, podiatrist, doctors, and pharmacy.

*Helen Selman*
*Palmetto, Georgia*

**Give yourself a hand against breast cancer**



Breast self-examination is easy, takes only a few minutes and can be performed in the privacy of your own home. It's an important way you can detect early and highly curable breast cancer.

*Take control of your body and your life.*

Make breast self-examination a part of your monthly routine. And see your doctor regularly for clinical exams and advice on mammography.

For a free pamphlet about breast self-examination, call your local American Cancer Society.

We're here to help.

AMERICAN CANCER SOCIETY®

# *PIP, The General Assembly, and You*

*Jack F. Menendez, M.D.*

As the 1988 State Legislative session draws near, we need to reaffirm our willingness to participate in the legislative process. PIP (the Physician Involvement Program) allows us to participate *and make a difference.* You get to know your legislator and tell him, one on one, of your concerns and interests. You also go to committee hearings, floor debates, and learn how the General Assembly functions.

While we will have a competent lobbying effort, lobbying alone cannot accomplish our goals without the presence of our physician members. Frequently, some of the para-medical groups exert influence beyond their importance by having a large turnout at the Capitol.

Since about one in five of all the bills introduced last year were medical related, we physicians have a big stake in the General Assembly's activities.

You will be receiving a letter asking you to participate. Please decide to be a part of PIP, we need your help. We will have staff present to brief each physician so he will be fully informed on the issues being discussed at that point in time.

I think you will find it an informative, interesting, and challenging day. It will also be a day that can make a difference for our profession.

Jack F. Menéndez

## NEW MEMBERS

Alossio, Frank V. — MAA — (Student), 1461-D Willow Lake Dr., Atlanta, GA 30329

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## QUOTES

*Defeat ceases when the ghost stops dancing.*
DEENA METZGER

*What great thing would you attempt if you knew you could not fail?*
ROBERT SCHULLER

*If you want to succeed you should strike out on new paths rather than travel the worn paths of accepted success.*
JOHN D. ROCKEFELLER

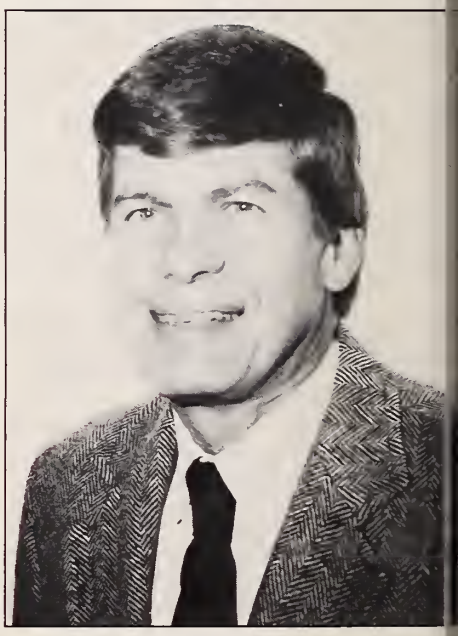
## PERSONALS

**DeKalb Medical Society**

**Andrew P. Morley, Jr., M.D.,** of Decatur, was elected chairman of the Board of Directors of the American Academy of Family Physicians at the Academy's 39th Annual Convention and Scientific Assembly in San Francisco last September. He has been a member of the Board of Directors for 2 years and currently chairs the AAFP commission on Membership and Membership and Member Services. He also chaired the Public Relations Committee.

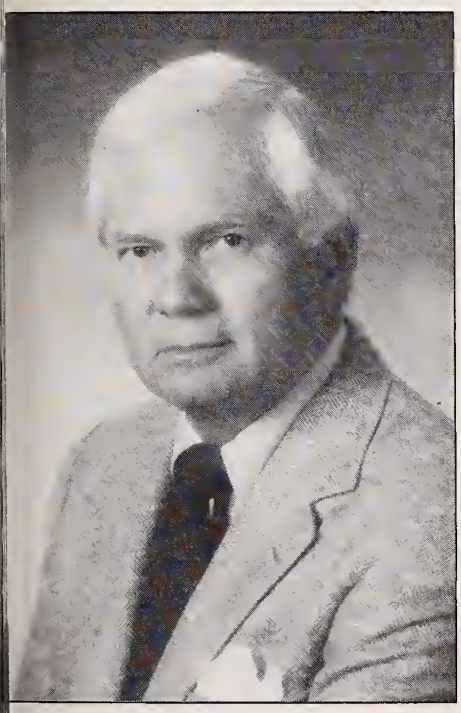
**Medical Association of Atlanta**

**Edwin C. Evans, M.D.,** of Atlanta, an internist and 39-year member of the medical staff at Georgia Baptist Medical Center has been appointed as the Medical Center's first Director of Geriatrics. Dr. Evans will serve as medical director of Georgia Baptist's Center for Older Adult Services and Newtonhouse, a long-term care facility. His role at the Center is to develop C*A*R*E (Center for the Assessment and Referral of the Elderly), a multidisciplinary outpatient assessment clinic serving older adults and their families throughout Georgia.



**J. R. B. (Jim) Hutchinson, M.D.,** of Atlanta, was installed as President of the American Academ of Otolaryngic Allergy, Inc. at its recent Annual Meeting held in Chicago. A private practitioner, Dr Hutchinson became a Fellow of th AAOA in 1969 and served on the Council and as Secretary before becoming President-elect. One of his interests is the legislative area, and he has served on legislative committees of several societies including appointments as chairman of the legislative committees of the Medical Association of Atlanta and the Georgia Society of Otolaryngology. Dr. Hutchinson has also been President of the Greater Atlanta an Georgia Societies of Otolaryngology.

**ɔuth Georgia Medical Society**



Valdosta otolaryngologist, **Henry ·iggs Smith, M.D.,** was one of 27 ndidates from throughout the S. and Canada to pass the llowship exam of the American :ademy of Otolaryngic Allergy, ven September 16, 1987 in ıicago, Illinois. The 4-hour amination covered the areas of ımunology, inhalant allergy, and od allergy.

## ɔCIETIES

The *Floyd-Polk-Chattooga ɜdical Society* met last October 6 r their annual Seafood Festival, at ıich time they honored those ıysician members who had acticed medicine in the area and d retired from practice. Since 82, 21 physicians from the ɜdical Society have retired. These ıysicians had accumulated a total approximately 760 years of rvice of the profession.

As speaker, Mr. Mike McDougald, President of McDougald Broadcasting Corporation, gave an outstanding tribute to these doctors who had served so long in practice. Each of the physicians was presented with a Georgian Cup which was elegantly wrapped by members of the Medical Auxiliary. Those who were honored at the Seafood Festival are: Lee Battle, Jr., Ed Bosworath, Emmett Brannon, Boyce Brice, Crawford Brock, Larry Cauthen, Ray Corpe, Ed Flowers, Gus Gafford, Warren Gilbert, Lester Harbin, William Harbin, Thad Mathney, Elio Sanchez, Charlie Smith, Ingrid Stergus, Ray Waters, Barbara Wyatt, and C. J. Wyatt, Jr.

## DEATHS

### McLeod Patterson, M.D.

Columbus internist McLeod Patterson, age 72, died last October at his home.

Dr. Patterson was born July 18, 1915, in Talladega, Ala., son of Lorenzo Dow Patterson and Margaret Patterson. He served in the U.S. Army during World War II, reaching the rank of lieutenant colonel.

He received his undergraduate degree from the University of Florida at Gainesville and was a graduate of Tulane University Medical School, New Orleans. He served as an intern at Charity Hospital, New Orleans, and practiced internal medicine in Somerset, Ky., for 15 years before coming to Columbus in 1966 as director of medical education at The Medical Center. In 1967 he headed a research program there that studied the effects of lead salts on humans, and in 1968 he directed opening of the first coronary care unit in the city there. He later entered private practice and remained on the staffs of The Medical Center and St. Francis Hospital until his semi-retirement in 1983. He was a member of First Presbyterian Church.

Survivors include his wife, two sons, and four grandchildren.

## QUOTES

*I believe that man will not merely endure; he will prevail . . . because he has a soul, a spirit capable of compassion and sacrifice and endurance.*
WILLIAM FAULKNER

*To be rich is not the end, but only a change of worries.*
EPICURUS

*I look upon the whole world as my fatherland, and every war has to me the horror of a family feud.*
HELEN KELLER

*Why can't we build orphanages next to homes for the aged? If someone's sitting in a rocker, it won't be long before a kid will be in his lap.*
CLORIS LEACHMAN

*I have a very strong feeling that the opposite of love is not hate — it's apathy.*
LEO BUSCAGLIA

*We abuse land because we regard it as a commodity belonging to us. When we see land as a community to which we belong, we may begin to use it with love and respect.*
ALDO LEOPOLD

*The great need for anyone in authority is courage.*
ALISTAIR COOKE

# CALENDAR

## JANUARY

11-15 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

22-23 — *Atlanta:* **Vitreoretinal Seminar.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

22-23 — *Atlanta:* **MAG Annual Leadership Conference.** Contact MAG, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224 (in Georgia).

25-29 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## FEBRUARY

1-5 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

4-9 — *Atlanta:* **American Academy of Orthopaedic Surgeons.** Category 1 credit. Contact AAOS, 222 S. Prospect, Park Ridge, IL 60068. PH: 312/823-7168.

15-19 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

17 — *Atlanta:* **Pulmonary Forum.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

20 — *Atlanta:* **Advances in the Treatment of Coronary Artery Disease.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

27 — *Atlanta:* **Advances in the Treatment of Acute Ischemic Heart Disease.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

27-28 — *Atlanta:* **Georgia Society of Anesthesiologists.** Category 1 credit. Contact Stanley Mogelnicki, MD, 5665 Peachtree Dunwoody Rd., Atlanta 30342. PH: 404/256-7324.

## MARCH

7-11 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

10-17 — *Copper Mountain, Co.:* **Snow Job in Gynecology and Obstetrics.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

11-12 — *Atlanta:* **25th Annual Ophthalmology Conference.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

21-26 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

24-26 — *White Sulphur Springs, WV:* **10th Annual Pediatric Postgraduate Course Sponsored by Scottish Rite Children's Hospital.** Category 1 credit. Contact Darlene Baugus, SRCH, 1001 Johnson Ferry Rd., Atlanta 30363. PH: 404/256-5252.

25-26 — *Atlanta:* **Hoke Kite Symposium on Children's Orthopaedics.** Sponsored by Scottish Rite Children's Hospital. Category 1 credit. Contact Darlene Baugus, SRCH, 1001 Johnson Ferry Rd., Atlanta 30363. PH: 404/256-5252.

27-31 — *Atlanta:* **American College of Cardiology.** Category 1 credit. Contact ACC, 9111 Old Georgetown Rd., Bethesda, MD 20814. PH: 301/897-5400.

## APRIL

6-8 — *Atlanta:* **What's New in Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

14-17 — *Atlanta:* **American College of Preventive Medicine Annual Meeting.** ACPM, 1015 15th St., Suite 403, Washington, D.C. 20005. PH: 202/789-0003.

15 — *Atlanta:* **Hepatic Surgery.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

18-22 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

21-22 — *Atlanta:* **Emory University Annual Renal Research Conference.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-27 — *Sea Island:* **Masters in Gynecology and Obstetrics.** AMA Category 1 and ACOG Cognate credits. Contact Office o CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

# Physicians — Part of the Community, Too

*Vickie Skandalakis Scaljon, M.A.*
*John E. Skandalakis, M.D., Ph.D., F.A.C.S.*
*Stephen W. Gray, Ph.D.*

*O MAN is an island,
entire of itself; every
an is a piece of the
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ain; if a clod be washed
way by the sea, Europe is
e less, as well as if a
omontory were, as well
if a manor of thy friends
of thine own were; any
an's death diminishes
e, because I am involved
mankind; and therefore
ever send to know for
hom the bell tolls; it tolls
r thee.*

JOHN DONNE, *1573-1631*

HOW MANY TIMES have we come across the term "well-unded" in our reading? "Well-unded" seems to be a descriptive ortcut of the ancient Greek ilosophy, "everything in oderation," or the Aristotelian, olden mean of the middle way."

s. Scaljon is on the Board of Directors of the ton County Heart Unit, on the Georgia State ard of the Arthritis Foundation, and President-ct of the Womens' Auxiliary of Piedmont spital; Dr. Gray is Professor Emeritus of atomy at Emory University; Dr. Skandalakis is ior Attending Surgeon at Piedmont Hospital in anta. Dr. Gray is also Associate Director, and Skandalakis is Chris Carlos Professor and ector, The Thalia and Michael Carlos Center for gical Anatomy and Technique.
end reprint requests to Dr. Skandalakis at 1440 ton Rd., Atlanta, GA 30322.

"Well-rounded" is one of those euphemisms found in college catalogs and prep school manuals depicting the type of student the institution hopes to mold: a student who not only does well academically but who participates in sports and is involved in the arts.

We remember those "fun" (i.e., easy) courses we had to take in college to round us out before we threw ourselves into the intensity of study to fulfill our major requirements — courses like art, drama, and music. In a three-month-long quarter, students were expected to absorb the best of music, art, and drama. Then when we graduated and began making our way into the world, we would be prepared not only to go to the symphony, a play, or a museum but also to understand and appreciate everything we were seeing and hearing.

Those little courses were supposed to round us out — along with throwing a few volleyballs or running around the track in physical education.

If you expected to be rounded out in graduate school, forget it! The studies were so concentrated that your only physical exercise was shuffling from one class to another. As for art, music, literature, and drama, you were on your own.

And during internship and residency, what did you do to round yourself out? Maybe you went to a movie and dinner if you could afford it; that is, before collapsing into a death-like sleep until you had to get up and get on the "on call" merry-go-round again.

You'd keep telling yourself, "When I get through with my residency, I'll relax, enjoy art, go to New York once a year to get culture, join the country club if possible, play tennis, take an exotic trip every year, read current best sellers together with the medical books and so on and so forth."

If you are a practicing medical doctor today and do all these things, including attending your kids' soccer games, basketball games, and baseball games, then you must be well-rounded.

We certainly are not the judge of which M.D. is well-rounded, but we do subscribe to that old Greek philosophy, "everything in moderation."

How involved are you with the world or, to put things in perspective, your family and community? After all, you can't just think medicine 18 hours a day and nothing else.

Have you gotten involved with your children's school? Have you gone to church, maybe even attended a Sunday school class? Have you spent your day off browsing through art galleries or your local museum? If you don't play tennis, have you taken a walk around your neighborhood, not only for exercise but to admire the greenery?

Are you involved in any of the charities that have to do with your specialty, like the Cancer Society, the Heart Association, or the Kidney Foundation?

Do you read a newspaper? (I don't mean just the sports page.) And last but not least, don't say politics is only for lawyers. Get involved; let the state legislature hear your voice.

The key to keeping your sanity and keeping your life in perspective is getting involved. Have you written a letter to your congressman, senator, or the president about the insurance crisis that plagues all industry and business, especially the medical profession?

There are so many good causes around these days that need your time and/or your money. You don't need to be a Renaissance man and be involved in everything that's going on in your community. You can pick and choose your areas of involvement. You are very well educated, but that education has been a concentration on one subject. By all means we must know about yesterday and by all means we must know what is going on today. Be involved and be informed.

So now that you're out of medical school and through with residency and fellowships — or even if you've been in practice for years — go ahead, round out!! Get involved! You can make time for church or charity work, gourmet cooking, or even growing roses if it suits you. Just remember these lines from philosopher Edmund Burke (1729-1797), "The only thing necessary for the triumph of evil is for good men to do nothing."

We think people today expect a little more from their physicians. Being involved in charities or philanthropic organizations, education, community, state and federal problems is not a waste of time.

The editor of this journal, Dr. Charles Underwood, in his acceptance speech as president of the Georgia Surgical Society, gave the following beautiful advice:

1. Be adaptable
2. Stand firm on proven principles
3. Seek out the joy and fascination
4. Be proud and protective

We agree. Get involved. The doors of the Society are open. ■

To understand much of what we're doing with respect to cancer research, you'd need a graduate degree in microbiology or biochemistry.

But to understand how well our educational programs and service resources help both patients and their families, simply talk to one out of every 100 Americans who are part of our volunteer program. Or talk to one of the 3 million who've survived cancer.

The battle isn't over but we are winning.

Please support the American Cancer Society

AMERICAN CANCER SOCIETY®

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

**WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

**Contraindications:** Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings:** **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum $K^+$ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict $K^+$ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

**Precautions:** The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

**Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.**

BRS-DZ:L42

# In Hypertension*... When You Need to Conserve $K^+$

# Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum $K^+$ and BUN should be checked periodically (see Warnings and Precautions).

Potassium-Sparing

**DYAZIDE®**

**25 mg** Hydrochlorothiazide/**50 mg** Triamterene/SKF

**Over 20 Years of Confidence**

The unique red and white Dyazide® capsule: Your assurance of SK&F quality.

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Carolina, P.R. 00630

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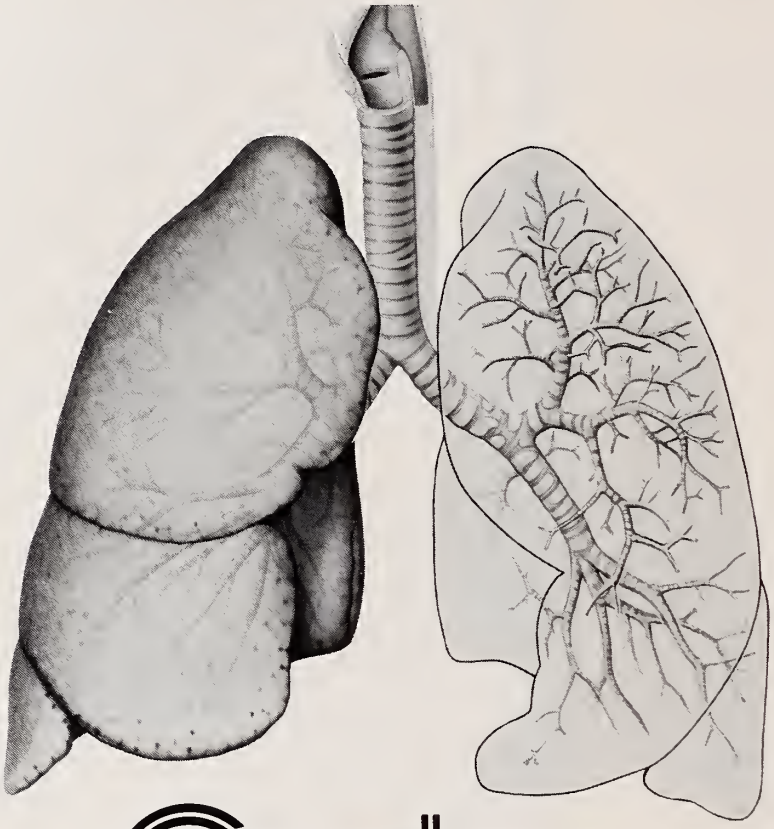
# Consider the causative organisms...



# Ceclor®
## cefaclor

## 250-mg Pulvules® t.i.d.
## offers effectiveness against the major causes of bacterial bronchitis

*Haemophilus influenzae* and *Streptococcus pneumoniae*
(ampicillin-susceptible and ampicillin-resistant)

*Note:* Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

**Summary. Consult the package literature for prescribing information.**

**Indication:** Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae*, and *Streptococcus pyogenes* (group A $\beta$-hemolytic streptococci).

**Contraindication:**
Known allergy to cephalosporins.

**Warnings:**
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

**Precautions:**
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

**Adverse Reactions:** (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology:
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly). [061787L]

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Lilly

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**Eli Lilly Industries, Inc**
Carolina, Puerto Rico 00630

"Living in the city
is lonely enough...
with herpes it's like
solitary confinement."
ZOVIRAX®
(acyclovir)
CAPSULES
Prevent genital herpes
recurrences
month after month with
daily therapy.
(In controlled studies, recurrences were
totally prevented for 4 to 6 months in up to
75% of patients.)
Please see last page of this advertisement for
brief summary of prescribing information.

# ZOVIRAX®
# (acyclovir)
# CAPSULES

## Help free your patients from recurrences.

## Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks —month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

## Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

## Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

*Please see brief summary of prescribing information on next page.*

# Prevent recurrences month after month*

# ZOVIRAX® (acyclovir) CAPSULES

Brief Summary

**INDICATIONS AND USAGE:** Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psycho-social difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

**First Episodes** (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

**Recurrent Episodes:**

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

**CONTRAINDICATIONS:** Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

**WARNINGS:** Zovirax Capsules are intended for oral ingestion only.

**PRECAUTIONS: General:** Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

**Drug Interactions:** Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the $F_1$ generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

**Pregnancy:** ***Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS — Short-Term Administration:** The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

**Long-Term Administration:** The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

**DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes:** One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

**Chronic suppressive therapy for recurrent disease:** One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

**Intermittent Therapy:** One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

**Patients With Acute or Chronic Renal Impairment:** One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance $\leq 10$ ml/min/1.73/m$^2$.

**HOW SUPPLIED:** Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200" - Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

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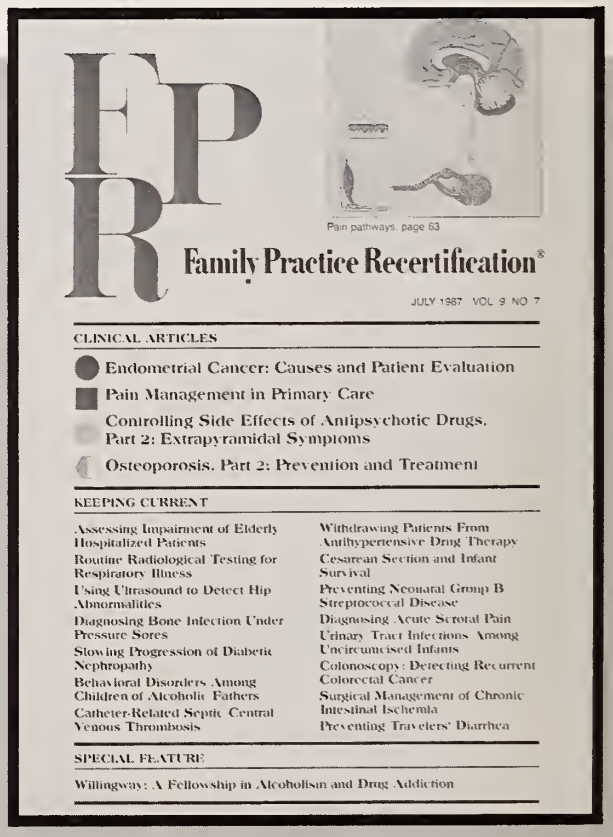
FPR
Pain pathways, page 63
Family Practice Recertification®
JULY 1987 VOL 9 NO 7
CLINICAL ARTICLES
Endometrial Cancer: Causes and Patient Evaluation
Pain Management in Primary Care
Controlling Side Effects of Antipsychotic Drugs. Part 2: Extrapyramidal Symptoms
Osteoporosis. Part 2: Prevention and Treatment
KEEPING CURRENT
Assessing Impairment of Elderly Hospitalized Patients
Routine Radiological Testing for Respiratory Illness
Using Ultrasound to Detect Hip Abnormalities
Diagnosing Bone Infection Under Pressure Sores
Slowing Progression of Diabetic Nephropathy
Behavioral Disorders Among Children of Alcoholic Fathers
Catheter-Related Septic Central Venous Thrombosis
Withdrawing Patients From Antihypertensive Drug Therapy
Cesarean Section and Infant Survival
Preventing Neonatal Group B Streptococcal Disease
Diagnosing Acute Scrotal Pain
Urinary Tract Infections Among Uncircumcised Infants
Colonoscopy: Detecting Recurrent Colorectal Cancer
Surgical Management of Chronic Intestinal Ischemia
Preventing Travelers' Diarrhea
SPECIAL FEATURE
Willingway: A Fellowship in Alcoholism and Drug Addiction

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# The Money of Politic$

Senator Roy E. Barnes

***We all remember who helped us in political campaigns, but to expect an officeholder to vote your way simply because you contributed to him or her is unreasonable.***

THERE IS PROBABLY NOTHING more misunderstood than the purpose and impact of campaign contributions. First, there can be little doubt that campaigns have become an expensive undertaking. When I first ran for the General Assembly some 13 years ago, a campaign cost generally between $8000-$10,000. Today a campaign in an urban area such as Cobb County can easily run $75,00-$100,000. As one political wag once remarked, "Money is the mother's milk of politics."

However, money and contributions do not *buy* an officeholder. They generally do guarantee access to an officeholder, as we all remember who helped us in political campaigns, but to expect an officeholder to vote your way simply because you contributed to him or her is unreasonable.

Contributions from Political Action Committees (PACs) are a growing part of the political process. Where individuals having a common interest concentrate their contributions and give one amount through a PAC, the impact can be dramatic. I have often thought, however, that where a PAC contributes money, it should list the local contributors, so an officeholder can still feel it is local people who care.

Lastly, even though contributions are important, don't forget that we all need help in contacting voters. Physicians are especially valuable in influencing their friends and patients in a political campaign. This is probably the most underutilized resource physicians have. Physicians are generally well involved in their community, but when it comes to political matters, most physicians leave the decisions to someone else. Also, in trying to influence voters, remember to talk about other issues rather than medical ones. Many of your patients have other interests, and the best way to influence them is to be cognizant of their concerns.

***If any of us fail to have influence in the process of government, it is only because we fail to be involved.***

Politics is not a dirty word. It is the process of governing ourselves. If any of us fail to have influence in the process of government, it is only because we fail to be involved. Your individual support and the support through your PAC assures that your concerns will be heard. ■

Senator Barnes represents Cobb County in the Georgia State Senate. Direct inquiries to him at Capitol Office, 109 State Capitol, Atlanta, GA 30334.

## Medical Association of Georgia's 4th Annual

# Leadershi

YOU MAY RECALL last year's MAG Leadership Conference, hailed by attendees as one of the most incisive medical economic updates in recent memory.

This year we're out to do it again: bring Georgia physicians the latest word, from the most qualified speakers, on today's medical marketplace and the forces affecting your practice of medicine.

It's the Medical Association of Georgia *1988 Leadership Conference,* to be held next January 22-23 at the Stouffer Waverly Hotel in northwest Atlanta.

All Georgia physicians and their spouses are invited to attend. MAG members, Auxilians, and county or specialty society staff are especially urged to attend.

The complete Leadership Conference schedule appears in this *Journal*, along with your Registration Form. We invite you to examine our program . . . and join us at the meeting!

### LEADERSHIP CONFERENCE HIGHLIGHTS

***Friday Afternoon, January 22: Dr. "Stormy" Johnson, Medical Economics, Hospitals, IPAs, and the Feds***

To open our meeting at 1 p.m. on Friday, we are privileged to have as our Keynote Speaker the rising star of the AMA Leadership — newly elected AMA Vice Speaker *Daniel H. "Stormy" Johnson, M.D.*, of Metairie, Louisiana. Dr. Johnson, a strong believer in the individual's ability to achieve, will speak on "Our Profession's Challenges and the Role of the Individual Physician."

Then, as we always do at this meeting, we look at the medical marketplace and the forces affecting your delivery of patient care. We are delighted to have *Mr. Don L. Berg,* Editor of the acclaimed journal, *Medical Economics*, with us this year. Mr. Berg has chosen as his topic, "Why I'm Bullish About Private Practice in 1995" — an interesting forecast, given the troubles which private practice faces today. Also gazing into the crystal ball will be *Alexander H. Williams III,* Senior Vice President of the American Hospital Association, speaking on "How Much Control Will Hospitals Have in the Future Medical Marketplace?"

Following Mr. Williams will be *William G. Kopit*, Washington attorney and adviser to the Georgia Health Network, speaking on "The IPA Model as Physicians' Representative in Medical Economic Issues." Finally, our concluding afternoon speaker will be *John S. Zapp, D.D.S.,* Director of the AMA's Division of Government Affairs in Washington. Dr. Zapp's topic is "Government's Role in the Marketplace: How the Future Looks."

After giving our speakers an opportunity to discuss points raised by the audience, we will end the day with a reception, from 6:00 to 7:30 p.m.

## January 22-23, 1988

# Conference

**Waverly Hotel**
**Atlanta**

***turday, January 23: AIDS, Dr. Ferroll ms, Physician Dispensing, and Generics***

The AIDS epidemic is our subject for Saturday morning's portion of the program, and our speakers are among those in the forefront of combating the epidemic. To open the morning panel, we are honored to have Georgia's own, *J. Roy Rowland, M.D.*, of Dublin, the only physician serving in the United States Congress. We have asked Dr. Rowland to present us with "A Physician's Perspective on the Government's Fight Against AIDS." Following him will be *James Curran, M.D.*, Director of the CDC's AIDS Project, as speaker. Dr. Curran has chosen as his title, "AIDS and HIV Infection: Can Physicians Provide Leadership?". And rounding out our session on AIDS will be *Larry O. Gostin, J.D.*, Executive Director, American Society of Law and Medicine, speaking on legal and medical-ethical issues facing the practitioner treating AIDS.

After lunch, we'll take a break from medical practice to hear from one of our state's most distinguished writers, Dr. Ferrol Sams, Jr., author of *Run With the Horsemen* and *Whisper of the River*, who will spin some yarns in his own inimitable style.

Then, for the rest of the afternoon, we'll discuss two significant issues affecting physicians today: the right to dispense medication in the doctor's office and Georgia's recently enacted generic drug law. First, the Honorable *Dan Coats*, Republican member of the U.S. House of Representatives from Indiana, will tell us why he's opposed to national legislation that would restrict the physician's right to dispense. Following Congressman Coats, we've secured *John H. Burkhart, M.D.*, Chairman of the AMA's Council on Ethical and Judicial Affairs, to present some thoughtful guidelines on dispensing. Offering comments on all this then will be Larry Braden, Executive Vice President of the Georgia Pharmaceutical Association.

Last October, the new Georgia generic statute took effect. Because of its considerable impact on the way physicians prescribe drugs, and its possible effects on patient care, we believe that the law deserves scrutiny. We've therefore arranged for spokesmen from both the Pharmaceutical Manufacturers Association (the "brand-name" vendors) and the Generic Pharmaceutical Industry of America to address the merits and impact of the new Georgia law.

As you can see, we've got quite a Conference in store. . . .

***Sunday, January 24: Special Optional Workshop on Office-Based Surgery***

Is office-based surgery a viable option for you? Last August, new Certificate-of-Need rules began to allow Georgia physicians to develop their own ambulatory surgery centers, which may be certified for Medicare

and other reimbursement.

For physicians considering an office-based surgical practice, MAG will hold an *Office-Based Surgery Workshop* on Sunday morning, January 24, as an optional addition to our Leadership Conference. The workshop will carry you from "point 1" — whether an ambulatory surgery center is viable for you — through state regulations and accreditation standards, how you can comply, and on to formulating a facility plan right for your practice.

### Registration for the Meeting

To register for the 1988 MAG Leadership Conference and optional Office-Based Surgery workshop, please complete the registration form inserted in this *Journal*, detach it from the hotel reservation form, and mail it with your registration fee to the MAG office.

**LEADERSHIP CONFERENCE**
**(Friday, Jan. 22 & Saturday, Jan. 23)**

| | MAG Member | Non-Member |
|---|---|---|
| Physician | $75 | $175 |
| Resident Physician | $25 | $40 |
| Auxilian/ Spouse | $25 | $40 |

**OFFICE-BASED SURGERY WORKSHOP**
**(Sunday morning, Jan. 24) *AND***
**LEADERSHIP CONFERENCE**

| | MAG Member | Non-Member |
|---|---|---|
| Physician | $160 | $260 |

### Hotel Accommodations

The MAG has secured an attractive guest-room rate at the stylish Stouffer Waverly Hotel, site of our previous Leadership Conferences. The rate for both singles and doubles is $80. To make your reservations at the Waverly, you may use the detachable lower portion of our Leadership Conference registration form, and mail it directly to the Hotel. Cut-off date for MAG reservations is December 31, 1987; after that, rooms may be had on a space-available basis.

We'll see you at the Waverly!

# The

## January 22
## Friday Afternoon

1:00 WELCOME & INTRODUCTION
*Jack F. Menendez, M.D.*
President
Medical Association of Georgia

1:10 INTRODUCTION OF KEYNOTE SPEAKER
*Charles D. Hollis, Jr., M.D.*
Chairman, Southeastern Delegation
AMA House of Delegates

1:15-1:35 KEYNOTE ADDRESS
OUR PROFESSION'S CHALLENGES, AND THE ROLE OF THE INDIVIDUAL PHYSICIAN
*Daniel H. Johnson, M.D.*
Vice Speaker
AMA House of Delegates
Metairie, LA

1:35-1:45 COMMENTS FROM THE AUDIENCE

**1:45-5:00 THE MEDICAL MARKE PLACE: CURRENT OUTLOOK, FUTURE PROSPECTS**

1:45-2:05 WHY I'M BULLISH ABOUT PRIVATE PRACTICE IN 1995
*Don L. Berg*
Editor, *Medical Economics*
Oradell, NJ

2:05-2:20 QUESTIONS & DISCUSSION

# Program

| | |
|---|---|
| 2:20-2:45 | HOW MUCH CONTROL WILL HOSPITALS HAVE IN THE FUTURE MEDICAL MARKETPLACE?<br>*Alexander H. Williams, III*<br>Senior Vice President<br>American Hospital Association<br>Chicago |
| 2:45-3:00 | QUESTIONS & DISCUSSION |
| 3:00-3:15 | BREAK — COFFEE & SOFT DRINKS |
| 3:15-3:40 | THE IPA MODEL AS PHYSICIANS' REPRESENTATIVE IN MEDICAL ECONOMIC ISSUES<br>*William G. Kopit*<br>Epstein, Becker & Green<br>Washington, D.C. |
| 3:40-3:55 | QUESTIONS & DISCUSSION |
| 3:55-4:20 | GOVERNMENT'S ROLE IN THE MARKETPLACE: HOW THE FUTURE LOOKS<br>*John S. Zapp, D.D.S.*<br>Director<br>AMA Division of Government Affairs<br>Washington |
| 4:20-4:35 | QUESTIONS & DISCUSSION |
| 4:35-5:00 | PANELISTS RESPOND<br>Mr. Berg<br>Mr. Williams<br>Mr. Kopit<br>Dr. Zapp |
| 6:00-7:30 | RECEPTION |

## January 23
## Saturday Morning

### 9:00-11:30 THE AIDS EPIDEMIC

| | |
|---|---|
| 9:00 | INTRODUCTION<br>Dr. Menendez |
| 9:05-9:30 | A PHYSICIAN'S PERSPECTIVE ON THE GOVERNMENT'S FIGHT AGAINST AIDS<br>*The Honorable J. Roy Rowland, M.D.*<br>United States House of Representatives<br>8th District, Georgia |
| 9:30-9:45 | QUESTIONS & DISCUSSION |
| 9:45-10:10 | AIDS AND HIV INFECTION: CAN PHYSICIANS PROVIDE LEADERSHIP?<br>*James W. Curran, M.D., M.P.H.*<br>Director of AIDS Project<br>Centers for Disease Control<br>Atlanta |
| 10:10-10:25 | QUESTIONS & DISCUSSION |
| 10:25-10:50 | COFFEE BREAK |
| 10:50-11:15 | LEGAL AND MEDICAL-ETHICAL ISSUES FACING THE PRACTITIONER TREATING AIDS<br>*Larry O. Gostin, J.D., Executive Director*<br>American Society of Law and Medicine<br>Boston |
| 11:15-11:30 | QUESTIONS & DISCUSSION |

* * * * * * * * * * *

| | |
|---|---|
| 11:30-1:00 | LUNCH ON YOUR OWN |

* * * * * * * * * * *

**1:00-1:30 Special Guest Speaker**

'THE WIDOW'S MITE" AND OTHER STORIES
*A. Ferrol Sams, Jr., M.D.*
Author of *Run With the Horsemen* and *Whisper of the River*
Fayetteville

## 1:30-5:00 PHYSICIAN DISPENSING AND GENERIC PRESCRIBING: ECONOMICS AND PATIENT CARE

1:30-1:40 THE PHYSICIAN'S RIGHT TO DISPENSE: HOW IT AFFECTS PATIENT CARE
*Richard A. Wherry, M.D.*
Chairman, MAG Committee on Physician Dispensing and Drugs
Dahlonega

1:40-2:00 NATIONAL LEGISLATION ON PHYSICIAN DISPENSING
*The Honorable Dan Coats*
United States House of Representatives
4th District, Indiana

2:00-2:15 QUESTIONS & ANSWERS

2:15-2:35 ETHICAL AND JUDICIAL CONSIDERATIONS OF DISPENSING
*John H. Burkhart, M.D.*
Chairman, AMA Council on Ethical and Judicial Affairs
Knoxville, TN

2:35-2:50 THE PHARMACISTS COMMENT
*Larry L. Braden*
Executive Vice President
Georgia Pharmaceutical Association

2:50-3:05 QUESTIONS & DISCUSSION

3:05-3:25 BREAK: COFFEE & SOFT DRINKS

3:25-3:35 PRESCRIBING IN GEORGIA: AN INTRODUCTION
*James A. Kaufmann, M.D.*
Chairman, MAG Council on Legislative Affairs
Atlanta

THE MERITS AND IMPACT OF GEORGIA'S NEW PRESCRIPTION LAW: TWO VIEWS

3:35-3:55 *Woodrow M. Allen*
Vice President — State Government Affairs
Pharmaceutical Manufacturers' Association
Washington, D.C.

3:55-4:15 *Kenneth Larsen*
Former Chairman
Generic Pharmaceutical Industry of America
New York

4:15-4:30 QUESTIONS & DISCUSSION

4:30 ADJOURNMENT

# MAG LEADERSHIP CONFERENCE

## January 22-23, 1988
## Waverly Hotel
## Atlanta

To register for our Annual Leadership Conference on Friday and Saturday, and optional Ambulatory Surgery Center Seminar on Sunday, please complete this Registration Form and return it with your check.

Name (please print) _____

Office Address _____

City _____ Zip _____ Office Phone _____

## Registration Fees (please check):

**LEADERSHIP CONFERENCE (Friday, January 22 - Saturday, January 23):**

| | MAG Member | Non-Member |
|---|---|---|
| ☐ Physician | $75 | $175 |
| ☐ Resident Physician | $25 | $40 |
| ☐ Auxiliary/Spouse | $25 | |

**OPTIONAL SEMINAR (Sunday, January 24):**
**OFFICE-BASED AMBULATORY SURGERY CENTER WORKSHOP**
Fee for Leadership Conference and Surgery Seminar

| | MAG Member | Non-Member |
|---|---|---|
| ☐ Physician | $160 | $260 |

CHECKS SHOULD BE MADE PAYABLE TO "MEDICAL ASSOCIATION OF GEORGIA." Payment must accompany this form. No refunds may be given after January 20.

DETACH THE TOP PORTION OF THIS FORM AND MAIL TO:

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938 Peachtree Street, N.E.
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*If you wish hotel accommodations at the Waverly, please complete, detach and mail this self-addressed, postage-paid card.*

---

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**(Rooms may not be available for check-in until after 3:00 P.M.)**

# MEDICAL ASSOCIATION OF GEORGIA
# ANNUAL LEADERSHIP CONFERENCE

## January 22-23, 1988

## Waverly Hotel
## Atlanta

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OPTIONAL WORKSHOP — SUNDAY MORNING, JANUARY 24

# OFFICE-BASED SURGERY: IS IT A VIABLE OPTION FOR YOU?

| | |
|---|---|
| 8:30 a.m. | WELCOME |
| 8:35 a.m. | WHY OFFICE BASED SURGERY?<br>*Diane S. Millman,* Health Law Specialist<br>McDermott, Will & Emery<br>Washington, D.C. |
| 9:00 a.m. | WHAT ARE THE ECONOMICS OF OFFICE-BASED SURGERY?<br>*Robert Marasco*<br>Robert Marasco Associates<br>Colorado Springs, Colorado |
| 10:30 a.m. | BREAK |
| 10:40 a.m. | OBTAINING NATIONAL ACCREDITATION<br>*Ronald Moen,* Executive Director<br>Accreditation Association for Ambulatory Health Care<br>Skokie, Illinois |
| 11:40 a.m. | MEETING STATE REQUIREMENTS: CERTIFICATE OF NEED AND LICENSURE<br>*Annette Maxey,* Executive Director<br>State Health Planning Agency<br>*Marty Rotter,* Director<br>Georgia DHR Office of Regulatory Services |
| 12:10 p.m. | OFFICE-BASED SURGERY SUITES: PERSPECTIVES<br>*John Munna, M.D.,* Plastic Surgeon, Atlanta<br>*Robert Stewart, M.D.,* Consultant, Stewart & Associates, Atlanta<br>*Pamela W. Allen,* Consultant, Allen Management Services, Inc., Atlanta |
| 12:45 | ADJOURN |

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# Demographics of Atlanta's Homicide Epicenter, 1984

Randy Hanzlick, M.D., F.A.C.P., Diane Jarret, M.D., George Birdsong, M.D.

**Abstract**

*During 1984, 31% of homicides in Fulton County occurred in a portion of Atlanta which contained about 11% of the population and 2% of the land area; that area was termed the "epicenter." The population of the epicenter was slightly younger than the general population and was largely black. Relative homicide density numerically approximated the relative density of persons living in public housing, which in turn reflected a number of adverse socioeconomic conditions. Firearms and liquor outlets were abundant in the epicenter, and the majority of homicides involved guns and/or alcohol. A total of 98% of the victims were black, probably reflecting the population of the area and the overall higher risk of homicide among blacks. Males and females were at highest risk in the 25 to 34 year age bracket, with the male rate being about four times that of females. Homicides tended to occur most commonly on the weekends (Saturday and Sunday) and were more prevalent between March and July than was observed county-wide. Data suggested that homicide was slightly more common in the last half of the month. Homicides were frequently preceded by an argument, which usually occurred inside, and frequently occurred near the victim's property. Most known perpetrators were black, and most lived in or near the epicenter. Similar observations over the past 35 years in Atlanta and other urban centers suggest that etiologic factors were complex, chronic, multicentric, and difficult to eliminate.*

## Introduction

During 1984, a total of 31% of all homicides that occurred within the boundaries of Fulton County happened in a 9 square mile area (3 mi. by 3 mi.) within the City of Atlanta. That area accounted for approximately 11% of the County's population and about 2% of the land area. This paper is a descriptive study of the demographics of that area and the homicides which occurred there. No attempt has been made to establish specific cause and effect relationships.

## Methods

All homicides which were known to occur in Fulton County during 1984 were plotted on a grid map consisting of multiple sectors of 1 square mile each. The smallest, square, multiple sector area which contained more homicides than any other area of the same size was selected for study and was termed the "epicenter." Demographic, income, and housing data were obtained from the Atlanta Housing Authority and 1980 U.S. Census Bureau for the 29 census tracts which fell within the epicenter. Details of each homicide were obtained by reviewing individual medical examiner case files. Comparisons were made to similar statistics which were available for the county as a whole. Additional information regarding perpetrators was ob-

Dr. Hanzlick is Associate Medical Examiner, Fulton County; Drs. Jarret and Birdsong are residents in pathology, Emory University and Affiliates.

Send reprint requests to Dr. Hanzlick, 50 Coca Cola Place, Atlanta, GA 30303.

tained from the Atlanta Police Bureau.

## Results and Discussion

*Location*

The epicenter was located in the southwest-central portion of the City of Atlanta. The 3 by 3 mile area was roughly defined by North Avenue, University Avenue, Boulevard, and a north to south line running through the point where Cascade Avenue originates at Gordon Street.

*Structural Aspects*

The epicenter was largely residential, many of the residential areas being directly adjacent to main city streets zoned for business. The epicenter contained the central downtown business district, Atlanta Fulton County Stadium, Grady Memorial Hospital, Crawford Long Hospital, Georgia Baptist Hospital, Georgia State University, Spellman, Morehouse, and Morris Brown Colleges, the State Capitol, the Fulton County and Atlanta Police Departments, Washington Park, Maddox Park, the Martin Luther King Center, the Civic Center, the World Congress Center, the Omni Sports Center, and eleven public transportation rail stations. Also within the epicenter were portions of Interstate 20 and the Interstate 75/85 Downtown Connector. Although located within the epicenter, very few homicides occurred in the central downtown business district or any of the landmarks noted above.

*Demographics and Housing*

Based on 1980 Census data, the population of the epicenter was approximately 66,000 persons or 11% of the total county population; the epicenter accounted for 2% of the land area and 31% of the homicides.

Age distribution of the epicenter's general population showed a slight shift toward a younger population (0-25 years) compared to the entire county. The epicenter's population was 90% black compared to 51% county-wide.

Table 1 summarizes much of the demographic data. the epicenter's relative homicide density of 15.5 exceeded its relative population density of 5.5 and approximated most closely the relative density of persons housed in public housing (15.6). Such a finding does not indicate a direct cause and effect relationship, however, since public housing is an indicator of other socioeconomic conditions such as poverty level, unemployment, and low educational status, many of which were of higher relative density within the epicenter. The cause and effect relationship between particular demographics and homicide is obviously complex and multifactorial; even more so when the potential role of biogenetics and ethnicity are considered. Such topics are beyond the scope of this descriptive paper.

A total of 34% of 50 Atlanta Housing Authority (AHA) communities were located within the epicenter, and about 31% of all persons residing in AHA housing county-wide did so in the epicenter. Twenty-three percent of all residents in the epicenter lived in AHA communities compared to 8% on a county-wide basis. About one-third of AHA communities in the epicenter housed primarily elderly individuals, who accounted for about 18% of persons in epicenter AHA Communities.

The relative density of firearm stores and liquor stores was also greater in the epicenter, but not quite in proportion to the population density. The role of guns and alcohol will be discussed in further detail below.

*Homicide Data*

Figure 1 illustrates the locations of homicides within the epicenter. Overall, homicides were dispersed

**TABLE 1 — Demographics of Epicenter Versus County-Wide Statistics, Atlanta, 1984**

| *Variable* | *County* | *Epicenter* |
|---|---|---|
| Total Population | 600,000 | 66,000 |
| Square Miles | 450 | 9 |
| % of Population | 100% | 11% |
| % of Land Area | 100% | 2% |
| % of Homicides | 100% (143) | 31% (44) |
| Population Density | 1333/SqM | 7333/SqM |
| Homicide Rate/100,000 | 24 | 68 |
| % Families below poverty | 18% | 45% |
| Mean Family Income | $23,425 | $10,345 |
| % Hholds on public assistance | 11% | 29% |
| % Hholds below $5000 income | 2% | 48% |
| % Hholds above $20000 income | 35% | 9% |
| % Female Head of Household | 28% | 50% |
| Unemployment | 7% | 12% |
| % Population in AHA Communities | 8% | 23% |
| AHA Population Density | 107/SqM | 1671/SqM |
| Liquor Store Density | 1.34/SqM | 5.7/SqM |
| Gun Store Density | 0.24/SqM | 0.77/SqM |
| Relative Population Density | 1 | 5.5 |
| Relative Homicide Density | 1 | 15.5 |
| Relative Homicide Rate | 1 | 2.8 |
| Relative % below Poverty | 1 | 2.5 |
| Relative Public Assistance | 1 | 2.6 |
| Relative Female Householders | 1 | 1.8 |
| Relative Unemployment | 1 | 1.5 |
| Relative % in AHA Communities | 1 | 3 |
| Relative AHA Population Density | 1 | 15.6 |
| Relative Gun Store Density | 1 | 3.2* |
| Relative Liquor Store Density | 1 | 4.2* |

*Based on data for City of Atlanta rather than Fulton County.

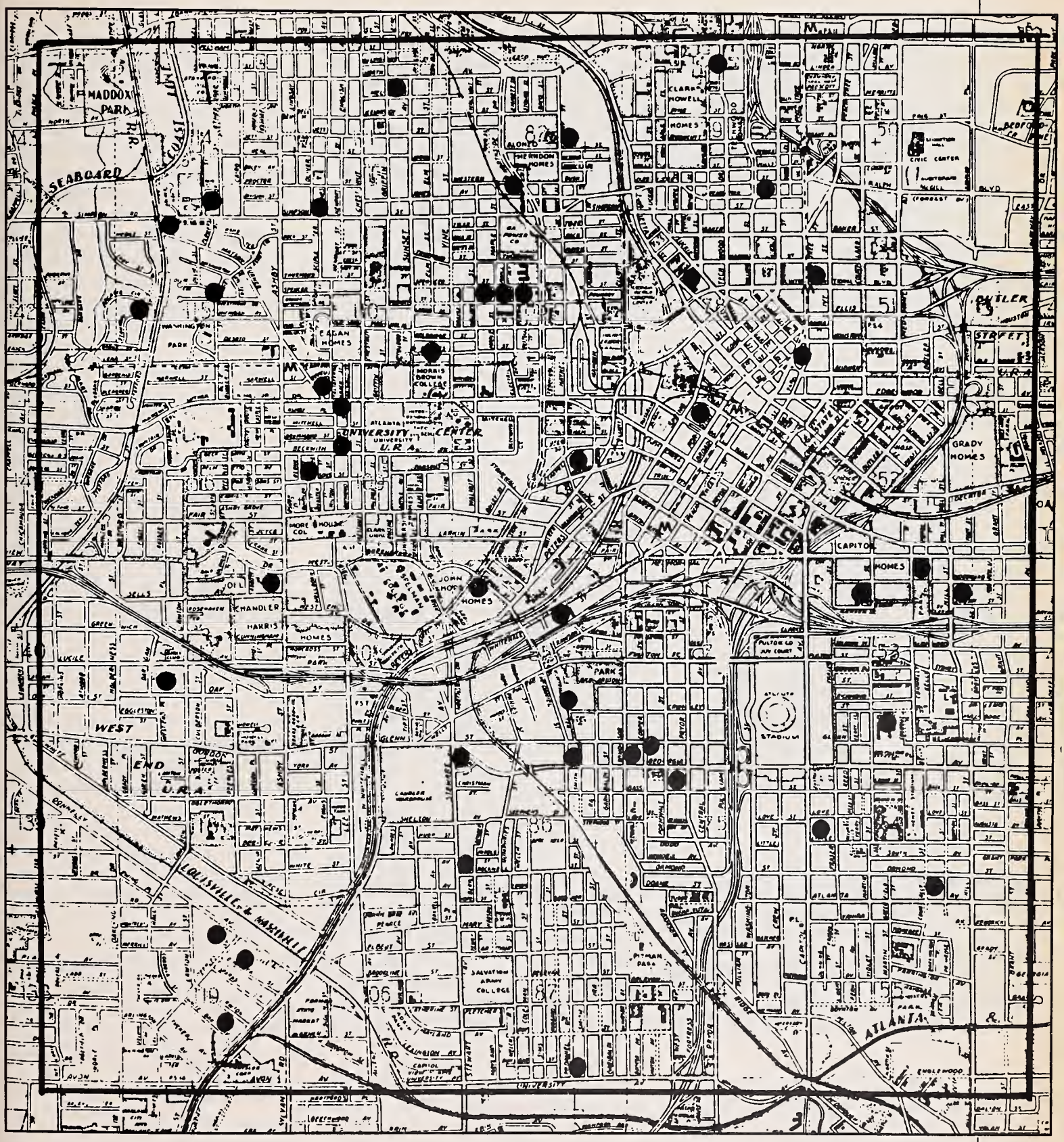


*Figure 1 — The smallest, square, multiple sector area which contained more homicides in Atlanta than any other area of the same size was selected for study and was termed the "epicenter." The epicenter was located in the southwest-central portion of the city, a 3 x 3 mile area roughly defined by North Avenue, University Avenue, Boulevard, and a north to south line running through the point where Cascade Avenue originates at Gordon Street.*

**TABLE 2 — Demographics of Population and Homicide Victims, County-Wide and in Epicenter Atlanta, 1984**

| *Category* | *County-Wide* | *Epicenter* |
|---|---|---|
| % Males in population | 47% | 45% |
| % Male victims | 77% | 87% |
| % Females in population | 53% | 55% |
| % Female victims | 23% | 13% |
| % Blacks in population | 51% | 90% |
| % Black victims | 84% | 91% |
| % Whites in population | 49% | 8% |
| % White victims | 16% | 9% |

**TABLE 3 — Age Distribution and Homicide Rates for Males and Females Within Epicenter. Age Distribution of General Population is Shown for Comparison. Rates Are Expressed in Terms of Deaths/100,000. Atlanta, 1984**

| *Age* | *% of Population* | *% of Victims* | *Homicide Rate* |
|---|---|---|---|
| *Males* | | | |
| 00-04 | 9.4 | 2.7 | 99 |
| 05-09 | 8.7 | 0 | 0 |
| 10-14 | 8.3 | 0 | 0 |
| 15-19 | 12.1 | 5.4 | 56 |
| 20-24 | 12.1 | 21.6 | 223 |
| 25-34 | 14.5 | 27.0 | 232 |
| 35-44 | 8.5 | 16.2 | 238 |
| 45-54 | 8.2 | 13.5 | 206 |
| 55-64 | 7.8 | 8.1 | 130 |
| 65-74 | 6.9 | 0 | 0 |
| 75+ | 3.4 | 2.7 | 99 |
| *Females* | | | |
| 00-04 | 7.3 | 0 | 0 |
| 05-09 | 6.6 | 0 | 0 |
| 10-14 | 6.6 | 0 | 0 |
| 15-19 | 10.8 | 14.2 | 25 |
| 20-24 | 11.4 | 14.2 | 24 |
| 25-34 | 13.4 | 57.4 | 61 |
| 35-44 | 8.5 | 0 | 0 |
| 45-54 | 8.5 | 14.2 | 32 |
| 55-64 | 9.4 | 0 | 0 |
| 65-74 | 10.3 | 14.2 | 27 |
| 75+ | 7.3 | 0 | 0 |

throughout much of the area, with tighter clustering in several subregions. The majority occurred at residential addresses.

As Table 2 illustrates, 40 of 44 epicenter homicide victims were black (91%). Since the epicenter population was 90% black, it is not surprising that nearly all victims were black. County-wide, despite a 51% black population, 84% of homicide victims were black. Thirty-four of the 40 black victims (85%) were male compared to 77% male victims county-wide. All four white victims were males; two were transients with no local address, one was killed by a fellow employee while working, and the other was a non-epicenter resident killed at a liquor store.

Table 3 shows the age distribution of victims for males and females, as well as the homicide rates for each age group. Males were at highest risk over a broad peak between 20 and 55 years of age, with the highest risk in the 25 to 34 year age group. Females were at relatively low risk except in the 25 to 34 year age bracket, where the homicide rate was about ¼ that of males the same age. The overall epicenter homicide rate of 68 per 100,000 was 2.8 times that of the county as a whole (24 per 100,000). Age ranged from 3 months to 82 years; there was one case of fatal child abuse in the epicenter compared to four for the county as a whole.

County-wide and epicenter perpetrator data were similar. The perpetrator was known to be a spouse, relative, or acquaintance in about 50% of cases at the time the case was reported to the medical examiner. It must be stressed that these data reflect what was known at the time of the incident and does not indicate final status after investigation by homicide or district attorney investigators. Thus, about one-half of homicides required further investigation to identify a perpetrator, who ultimately may be a stranger, spouse, relative, or acquaintance. Atlanta Police Bureau

***The authors wish to emphasize that describing a geographically defined epicenter tends to create the false impression of a highly localized phenomenon. Such is not the case. . . .***

information at the time of this writing indicated that less than 20% of the epicenter homicides remained unsolved. Of the resolved cases, 14% were black females killed by black males, 68% were black males killed by black males, and 7% were black males killed by black females. Thus, 89% of the resolved cases represented blacks killed by blacks. A total of 68% of the known perpetrators lived in the epicenter, and 12% lived adjacent to the epicenter; 80% of perpetrators, therefore, lived in or near the epicenter.

Fatal weapon distribution in epicenter homicides was similar to the county as a whole; nearly two-thirds of homicides were committed with guns. Stabbing was slightly more prevalent in the epicenter (22.7% versus 17.4%), and blunt trauma was slightly less prevalent compared to the entire county (9.1% versus 13.9%). Other mechanisms accounted for about 5% of homicides in each area.

Day of occurrence was similar in the epicenter and county-wide data; the majority of homicides occurred on Friday, Saturday, or Sunday, with a definite preference for Saturday and Sunday. Monday homicides were noticeably less prevalent in the epicenter (Table 4).

**TABLE 4 — Distribution of Homicides, by Day of Occurrence in the Epicenter and on a County-Wide Basis, Atlanta, 1984**

| *Day* | *Epicenter* | *County-Wide* |
|---|---|---|
| Monday | 4.5% | 12.0% |
| Tuesday | 13.6% | 12.0% |
| Wednesday | 9.1% | 9.0% |
| Thursday | 9.1% | 11.0% |
| Friday | 13.6% | 13.0% |
| Saturday | 25.0% | 22.0% |
| Sunday | 22.7% | 19.0% |
| Unknown | 2.3% | 2.0% |

**TABLE 5 — Distribution of Homicides, by Month for all of Fulton County and Epicenter, Atlanta, 1984**

| *Month* | *County-Wide (%)* | *Epicenter (%)* |
|---|---|---|
| January | 6.0 | 2.3 |
| February | 9.0 | 6.8 |
| March | 9.0 | 11.4 |
| April | 8.1 | 11.4 |
| May | 10.5 | 13.6 |
| June | 8.1 | 9.1 |
| July | 6.5 | 11.4 |
| August | 6.5 | 2.3 |
| September | 7.5 | 9.1 |
| October | 10.5 | 6.8 |
| November | 10.0 | 9.1 |
| December | 8.1 | 4.5 |

As Table 5 illustrates, county-wide data showed less month to month fluctuation in homicides than did epicenter data. A greater percentage of homicides occurred between March and July in the epicenter and a lower percentage between August and February compared to county-wide data.

***The demographics of Atlanta's 1984 homicide epicenter reflected observations noted in other urban centers, and the nature of homicides which occurred there also are similar.***

In the epicenter, 44% of homicides occurred within the first 16 days of the month, while 55% occurred during the remainder of the month. County-wide data showed essentially an even distribution. Admittedly, the number of homicides in the epicenter was relatively small, perhaps accounting for the observed difference. However, the 12 month collective total of days in the "first half of the month" was 192 compared to 173 for the "last half of the month" suggesting that the late month peak was real.

Table 6 summarizes additional characteristics of the epicenter homicides, which did not differ markedly from county-wide statistics. Essentially two-thirds of the victims lived within the epicenter. A total of 39% occurred in or near the decedent's residence, and an additional 7% occurred in the decedent's car. Thus, nearly half occurred in or on the decedent's property. Nearly one-fourth occurred in public places such as on a street or in a park or parking lot. Overall, at least 63% occurred *inside* a residential or business structure. Eighteen percent of the victims who lived in the epicenter were killed in the epicenter at a location other than their property or house. Seven percent of the epicenter homicides occurred at or near a bar.

Nine percent of the epicenter victims were killed while working. One

TABLE 6 — Summary of Circumstances and Place of Occurrence
Epicenter Homicides, Atlanta, 1984

| | |
|---|---|
| *lace of Occurrence:* | |
| n or Near Decedent's House or Apt | 39% |
| n Decedent's Car | 7% |
| n Perpetrator's House or Apt | 4% |
| n 3rd Party's House or Apt | 12% |
| t a 3rd Party Business (Hotel, Liquor Store, Food Plant) | 4% |
| t or Near a Bar | 7% |
| t a Public Place (on Street, in Park, etc.) | 23% |
| t a Vacant Building or Lot | 4% |
| Total | 100% |
| *esidence:* | |
| ictim Lived in Epicenter | 66% |
| ictim Did Not Live in Epicenter | 30% |
| ictim With Unknown Address | 4% |
| Total | 100% |
| *ther:* | |
| ictim Lived in Epicenter But Was Not Killed at Their Residence or in Their Car | 18% |
| ncident Occurred at a Place of Residence | 55% |
| ncident Occurred at a Business (Including Bars) | 11% |
| ictim Killed on the Job | 9% |

victim was a hotel secretary who was shot by a former boyfriend who then killed himself. A second was a cab driver who was shot in his cab. A third was a food plant employee who was stabbed by a coworker, and the fourth was a nightclub doorman shot by a disgruntled patron.

Detection of alcohol in the victims was similar in the epicenter and county-wide; about 50% of victims tested were positive for blood alcohol.

Circumstances surrounding the incidents were also similar in the epicenter compared to the entire county. An argument was known to immediately precede the incident in about 30% of cases. Robbery was initially suspected in 11% of cases and illicit drug transactions in 5% of cases. A total of 55% of the cases had no apparent motive listed at the time the case was reported to the medical examiner. Thus, for cases with known motives or precipitating factors, about two-thirds were preceded by an argument.

Turning now to previous studies of urban homicide, Munford, et al. reported that relatives or close friends kill most homicide victims, usually in a home, and victims of homicide are more often male than female and more often black than white.[1] Further, more homicides reportedly occur on weekends and most occur between 6 p.m. and 2 a.m. In studies from Cleveland and Houston, most homicides occurred on Saturday, followed by Sunday, then Friday.[2,3] The data in the present study of Atlanta/Fulton County are certainly consistent with the above findings, and age distribution of victims was similar as well.

Data presented by Bensing and Schroeder[2] showed that two-thirds of the homicides in Cleveland occurred in 6% of the City's area which contained 12% of the population; statistics which are again similar to those of the present study. Further, firearms were the method of choice in Cleveland, and areas with the highest homicide rates also ranked highly in multiple indexes of social need and maladjustment such as financial dependency, crowded housing, undesirable neighborhood conditions, socioeconomic status, and family adjustment problems. Despite that data being collected in the 1950s in a Northern city, homicide in Atlanta's 1984 epicenter was associated with similar socioeconomic conditions.

Also quite consistent with the Atlanta data is Danto's observation[4] that homicide generally occurs in the low grade residential areas in close proximity to business districts and that alcohol is commonly present in victims.

Previous investigators have examined homicide and some of the associated demographic data from Atlanta. Rivers[5] examined 1972 cases and divided the motives into two broad categories, expressive and instrumental. Expressive referred to homicides that were impulsive, such as those which result from sudden anger. Instrumental referred to homicides which were planned to some extent. He found that the motive was expressive in 79% of the cases examined. The proportion of cases in which the motive was expressive was similar in blacks and whites. The expressive character of 1984 epicenter homicides is apparent; for cases in which data were available, an argument immediately preceded nearly two-thirds of the homicides.

A total of 50% of the offenders in River's Atlanta study used handguns, and that proportion remained constant regardless of race. In 1972, handgun murders were three times more likely to be expressive than instrumental, but non-handgun homicides were more than five times as likely to be expressive than instrumental. Regardless, firearms (mostly handguns) remained the murder method of choice in the 1984 epicenter.

Imes[6] examined homicide statistics in Atlanta from 1958 to 1962 and found that the nature of the motive was most frequently an altercation of trivial origin or sudden an-

ger when the victim was male and a domestic quarrel when the victim was female. Those two categories accounted for more than half of the homicides in his study. In that study, the perpetrator and victim knew each other in the majority of cases, and in over half the cases the victim was a close friend, acquaintance, or family member. Imes determined that the victim was ultimately classified as a stranger in less than 10% of cases, most of the homicides were within race, those that were inter-racial tended to occur in robberies of whites by blacks, and 65% of victims were killed in their homes. The 1984 epicenter data were quite consistent with the findings of Imes from the 1960s, except that the four homicides of whites within the epicenter were not known to be related to robberies of whites by blacks.

***This paper is a descriptive study of the demographics of a specified area of the City of Atlanta and the homicides that occurred there. No attempt has been made to establish specific cause and effect relationships.***

Carlson[7] measured the distance from the perpetrator's address to the place of occurrence in Atlanta over two 4-year periods and found that the distance was less than 0.4 miles in 69% to 74% of cases. The finding that 80% of known perpetrators lived in or near the 1984 epicenter is certainly consistent with Carlson's findings.

Other factors that have been previously associated with homicide in Atlanta are income, population density, and time of occurrence. Rivers divided his Atlanta study into high and low income groups. Low income blacks represented 60% of the offenders, in his study, high income blacks represented 22% of offenders, low income whites constituted 7%, and high income whites 11% of offenders. Imes found that population density was an important variable at the extremes of high and low density and found no correlation of homicide rate and time of the year. Homicide rates were higher on weekend nights between 8 p.m. and 2 a.m. The present study did not examine the specific income of perpetrators, but population density correlations are consistent with findings for the 1984 epicenter. Also, the 1984 epicenter data did suggest that homicides had a greater tendency to occur between March and July in the epicenter than was observed county-wide; the county-wide data agreed with the findings of Imes.

The authors wish to emphasize that describing a geographically defined epicenter tends to create the false impression of a highly localized phenomenon. Such is not the case; homicides occur throughout much of the City of Atlanta and more sparsely in the remainder of the County, and the boundaries of the epicenter are more theoretical than real. Homicide is at its densest in the epicenter but is not confined there. Further, the epicenter described in this paper is not the only such area within Fulton County. It would appear that as the socioeconomic conditions of the epicenter fade or merge into surrounding areas, likewise do the general forces which culminate in "the usual" homicide, "sensational" homicides being relatively rare.

Of practical import is the fact that the epicenter is in close proximity to, and actually contains, major trauma centers and access to emergency medical services. Thus, the potential exists for saving persons who are seriously injured, and if the assault rate remains constant or increases, homicide rates may still decline since death is a prerequisite of homicide. Further, in cases where death does occur, the epicenter contains the Atlanta Police Bureau and its homicide division as well as the Fulton County Medical Examiner's Office. The proximity of the epicenter to these agencies facilitates not only death investigation, but police response to disturbances which may result in homicide if not averted.

Preliminary examination of data from 1985 shows findings similar to those presented in this paper. Data from early 1986, however, show geographic patterns of homicide which differ somewhat from the immediately preceding years, as well as a 30% increase in the homicide rate when comparing the first 5 months of 1986 to 1985. Homicide rates in Atlanta have fluctuated markedly in Atlanta over the past 25 years, but it may be important to determine whether recent trends reflect an increase in the homicide-associated conditions described in this paper, or whether new, different, or modified conditions account for the observed changes.

The Centers for Disease Control, in collaboration with the Atlanta Department of Public Safety, the Georgia Department of Human Resources, the Fulton County Medical Examiner, and the Fulton County Health Department are conducting a study of domestic homicide and assault in Atlanta/Fulton County in order to more specifically document long-term histories in specific homicide or assault victims and perpetrators. The study will examine the prior utilization of health care, social, police, and judicial services by families involved in domestic homicide or assault. Simply because of the mathematical correlation between relative homicide density and relative density of persons housed in public housing, an

interesting study would involve establishing what, if any relationships exist between specific homicide locations, victims, perpetrators, and public assisted housing. Long-term planning would seem most appropriately aimed at averting "the usual" homicide rather than "the sensational" due to the relative rarity of the latter.

### Summary

The demographics of Atlanta's 1984 homicide epicenter reflected observations noted in other urban centers, and the nature of homicides which occurred there also are similar. The population of the epicenter was slightly younger than the general population and was largely black. Relative homicide density numerically approximated the relative density of persons living in public housing, which in turn reflects a number of adverse socioeconomic conditions. Firearms and liquor outlets were readily available in the epicenter, and the majority of homicides involved guns and/or alcohol. A total of 98% of the victims were black, probably reflecting the population of the area and the overall higher risk of homicide among blacks. Males and females were at highest risk in the 25-to-34-year age bracket, with the male rate being about four times that of females. Homicides tended to occur most commonly on the weekends (Saturday and Sunday), and were more prevalent between March and July than was observed countywide. Data suggested that epicenter homicides were slightly more common in the last half of the month. Homicides were frequently preceded by an argument, usually occurred inside, and frequently occurred near the victims property. Most known perpetrators were black, and most lived in or near the epicenter. Similar observations over the past 35 years in Atlanta and other urban centers suggest that etiologic factors were complex, multifactorial, chronic, multicentric, and difficult to eliminate.

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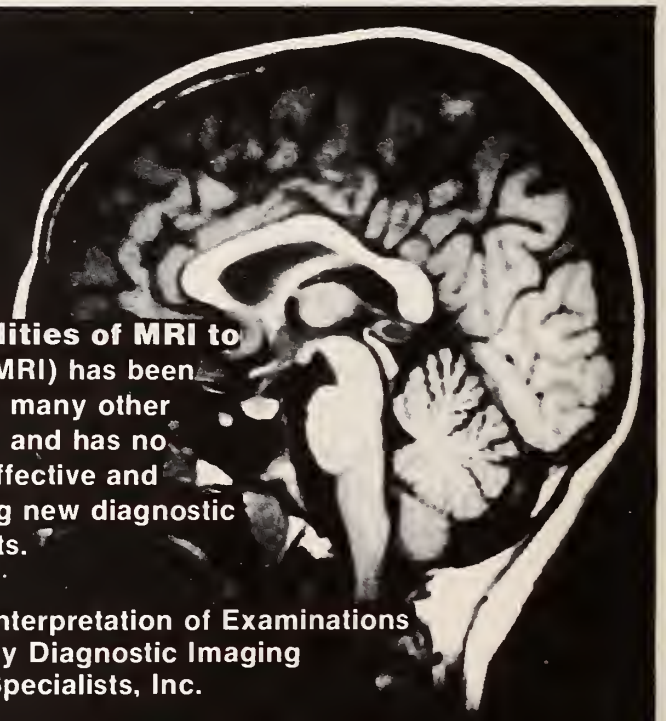

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# Adolescent Urine Drug Screening

## A Cobb County Medical Society Program

Dirk E. Huttenbach, M.D.

### Introduction

At its annual meeting in April, 1986, the MAG House of Delegates voted to "endorse the Cobb County Medical Society Adolescent Urine Drug Screen Program" and to "promote the Urine Drug Screen Program to its other component Medical Societies and encourage each society to set up a similar program." As of March, 1987, the program has spread to DeKalb County and Muscogee County with the backing of their respective medical societies. Interest has been expressed in at least six other Georgia counties to have a similar program established.

The Cobb County Medical Society Program officially started in June, 1985, with the participation of five Cobb County hospitals. It had been a project of the Cobb County Medical Society Ad Hoc Committee on Adolescent Drug Abuse. This committee is now a subcommittee of the Cobb County Medical Society Public Health Committee.

The idea of starting this program took form as a way of making urine drug screening more accessible to families as a preventive and early diagnostic tool, after it was noted that urine drug screening was helpful in preventing relapse in recovering addicts. It was also observed that there were incidents of early (youthful) drug abusers stopping drug use once urine drug screening was applied to them. Some of these adolescents never needed to enter formal treatment which made their "treatment" much less expensive and less complicated.

***The idea of starting this program took form as a way of making urine drug screening more accessible to families as a preventive and early diagnostic tool. . . .***

Dr. Huttenbach, a child and adolescent psychiatrist, is Chairman of the Cobb County Medical Society's Subcommittee on Adolescent Drug Abuse. Send reprint requests to him at 833 Campbell Hill St., Ste., 440, Marietta, GA 30090.

### Purpose

The purpose of the Adolescent Urine Drug Screen Program is to make it easier for parents to discretely determine whether their children are experimenting with or using illegal drugs. Unfortunately, many children and adolescents do use illegal drugs, but when parents ask about drug abuse, the child often denies it. As a result, drug abuse may go on for years, undetected and untreated, often creating severe behavioral problems or aggravating already present behavioral problems.

This program is designed to provide parents with more information about their child. It is also an opportunity for the child to demonstrate that he or she is not using drugs when, in fact, he or she is not. It is important to remember that adolescents can appear emotionally upset or hyperactive when not on drugs, but affected by life events or emotional disorder. It is hoped that this program can help restore trust in families where a question of possible drug abuse by the child has disrupted trust.

**Philosophical, Ethical, and Legal Questions**

Does this program violate the "rights" of children and adolescents to have their privacy respected? I feel that these presumed rights need to be balanced against the rights of parents to protect their minor children from potentially lethal illness. As an analogy, the DPT innoculation now protects children from potentially lethal illnesses but at times, parents, physicians, and nurses need to force children to have their shots. These injections, by needle, are very much an intrusion into the child's body space. Yet, they are a legitimate and potentially lifesaving exercise of parental authority.

Adolescent drug abuse probably kills at least 2,000 to 4,000 adolescents per year, through accidental overdoses, as well as motor vehicle and other accidents, suicides, and homicides. James H. Sammons, A.M.A. Executive Vice President, in the A.M.A. Medical News of January 23/30, 1987, noted that "alcohol and drug abuse kills 8,000 people younger than 18 each year and injures another 40,000." The combined mortality of diphtheria, pertussis, and tetanus is now down to about 40 cases per year which is less than 1% of what it was before immunization was instituted (calculated from Maxcy-Rosenau: Public Health and Preventive Medicine, 12th Edition, 1986).

The issue of confidentiality is a major one to many people. For this reason, we do not ask for the child's name to allow confidentiality. We have inquired about the child's age and sex so we can have a better idea of the population served. To protect the parent's interest, we label the test "Minor Child Modified Drug Screen" to make clear that this is a *minor child* result rather than a parent's personal urine drug screen results. This, we feel, helps protect parents in sensitive occupations such as policemen, pilots, or even physicians.

There is the issue of medical responsibility for patients. This program is carefully constructed as a *public service*, which screens urine specimens of *non-patients* whose identities are known only to the parents who bring in the specimen. Thus, there is no physician-patient relationship and no medical responsibility to anyone unless and until an appointment is requested with a physician for treatment.

***The program is carefully constructed as a* public service, *which screens urine specimens on non-patients who identities are known only to the parents who bring in the specimen.***

This point was raised early and answered satisfactorily by Mr. Chris Pascal, Senior Attorney, Public Health Division, U.S. Department of Health and Human Services, who stated,

> "The Federal confidentiality laws on drug abuse generally apply to the records of any patient who is treated, or diagnosed and referred for treatment, for drug abuse to the extent, that the drug abuse activity is Federally conducted, regulated or assisted. 42 U.S.C. 290ee-3(a); 42 C.F.R. 2.12(a). These laws do not apply to drug abuse activities involving non-patients. Since your program does not envision that the hospital would diagnose the child as a drug abuser or provide treatment to the child, we do not believe the child would be a "patient" under the regulations. 42 C.F.R. 2.11(i). Therefore, it is our opinion that the regulations would not apply.
>
> "However, if after the parent has received the urinalysis results the parent believes that professional intervention is necessary and refers the child for drug abuse treatment, the confidentiality regulations would apply to the extent that the treatment was federally conducted, regulated, or assisted. Under those circumstances, the provider of drug abuse treatment would generally need to obtain the child's consent in order to provide information from the child's patient record to the parent. 42 C.F.R. 2.15."

Of further assurance might also be recent tort reform legislation passed by the Georgia Legislature which provides for immunity for physicians when providing noncompensated public service.

Another commonly raised question is how the parent obtains the specimen from the child. This is an issue, we feel, that should be left up to the parent and the child. If the child adamantly opposes providing a specimen, it is safe to assume that the child either has been abusing drugs or is quite oppositional. If the child's attitude is one of cooperation, it is probably safer to assume that the child is not using drugs but it is still useful to go ahead with the test if only to make the point that the parent is concerned and willing to ask for a urine drug screen when appropriate, which then still makes it easier for the child to resist peer temptation. Some adolescents might consider a request for a urine sample as reflecting a lack of confidence of the parents in them. The parents should certainly feel free to be honest with their children particularly when they feel they have cause for being concerned such as when observing changes in the child's behavior. Ultimately, the main power that the parent has to obtain the urine specimen from the child is the power of persuasion backed by the shared need of the

parent and child to maintain a family atmosphere of trust. If, however, the parents' authority has been shattered already by the child and the child and the family's life becomes unmanageable, the parents should seek professional assistance.

### Cost

This program is designed as a public service; therefore, the expense to the parent is limited to a laboratory fee, payable to the participating hospital. This laboratory fee in 1986 in Cobb County ranged between $27.00 and $49.00. There is *no* emergency room fee and *no* physician's fee.

### Description

Parents are advised to obtain a urine specimen from their child, preferably in a clean glass container. In order to try to make sure that the sample is free of willful contamination, parents are advised to witness the child producing the specimen. The sample should be brought in soon, again to minimize the possibility of willful contamination. The specimen is brought to the participating hospital laboratory by the parents. Emergency room staff can assist in this and can handle collection of the laboratory fee.

Psychiatric physicians on participating Cobb County and DeKalb County hospital medical staffs have agreed to order a "minor child modified urine drug screen" on any urine specimen brought to their hospital under this program when the psychiatric physician is on call already for that hospital's emergency service. In Columbus, Georgia (Muscogee County), primary care physicians at three participating hospitals have preordered this test. The test is preordered and no additional order by the physician on emergency call is needed. This makes the program more convenient for volunteering physicians. In the case of one participating psychiatric hospital in Cobb County, it is the psychiatrist/director of adolescent services who has preordered the test. Results of the drug screen are provided by the laboratory to the physician who has preordered the test. The name and telephone number of the physician who has ordered the test is listed on the information sheet given to the parents by the hospital laboratory when the parent delivers the urine specimen. Parents are advised to call the ordering physician's office 5 or 6 work days after dropping off the specimen, during regular office hours, at which time the results should be available.

***It certainly behooves hospitals and physicians to deal with reputable and competent laboratories whose results are doublechecked and can be considered reliable.***

We ask that parents sign a consent for a drug screen. As noted on this form, the specimen will be accepted in the parent's name rather than the child's name. Thus, the child's name is not mentioned and his or her privacy is respected. We do ask parents to participate in this program in good faith and ask parents to agree to the following statement: "I certify that this sample was obtained from my minor child. I agree to indemnify the hospital and the physician for any liability that might result if this is not the case." This wording was suggested by attorneys of the American Psychiatric Association Legal Consultation Program.

We have set no requirements as to how the physician reports the laboratory results. We have suggested that this be done by telephone, as it is less time consuming. Some physicians may talk to the parents themselves. Others may have their office staff call. No charge is made by the physician for providing this information. If the parent wishes to discuss the child's situation at greater length or wishes to seek treatment, an appointment will need to be made either with that physician or with anyone else of the parent's choosing.

In Cobb and DeKalb Counties, the physicians involved so far have been psychiatrists. In Muscogee County, primary care physicians are involved also. We would foresee that most county programs, especially smaller non-urban counties, would utilize primary care physicians rather than psychiatrists. In urban counties or suburban counties where psychiatrists are more abundant, it is more possible to have psychiatric departments volunteer their services, although this service could be provided also through volunteering primary care physicians or addictionologists. Each county Medical Society can decide what is most feasible in its own jurisdiction.

### Possible False Laboratory Results

Concerns have been raised about the reliability of modified urine drug screens, especially following an article in *JAMA* on April 26, 1985. High false-positive rates were noted in samples submitted by the authors to 13 different laboratories. Possibly as a result of this article and because of the important medical legal questions raised by urine drug screen testing, better laboratories are now incorporating certain safeguards.

SmithKline Bio-Science Laboratories, which services most of the hospitals in Cobb County, doublechecks its positive results by using an entirely different laboratory method to confirm any positive results. Thus THC, the active ingredient in marijuana, is first screened for with an enzyme multiplied immunoassay technique (EMIT). If this test turns up positive, it is con-

firmed with a radioimmunoassay (RIA). Synthetic narcotics are first screened via thin layer chromatography (TLC). They are confirmed with a gas chromatography-mass spectrometry (GC-MS). Other drugs screened for are similarly double-checked. As a further safeguard, all urine specimens are saved for 1 week so that any specimen can be rechecked if there is any question. Lastly, it is always possible to have the patient provide another urine sample which can be checked. Admittedly, a later urine sample may not contain suspected drugs. It certainly behooves hospitals and physicians to deal with reputable and competent laboratories whose results are doublechecked and can be considered reliable.

False-negative tests do occur when the amount of drugs in a patient is below a certain cut-off point. We observed, however, that a number of children and adolescents have chosen to admit drug use after the urine sample has been taken, but before the test results came back negative. This we feel has helped foster greater communication and greater trust in the family, even though a false-negative result may have been reported.

### Results

At Kennestone Hospital from June 10, 1985, through December 13, 1985, a total of 25 specimens were brought in, of which 12 were drug positive (9 THC, 1 TCH and Valium, 1 cocaine, and 1 chlorpheniramine) for an average of about four requests per month. From December 13, 1985, through April 29, 1986, a total of 35 specimens were brought in, of which 17 were positive (13 THC, 1 cocaine, 1 hydroxyzine diphenhydramine, 1 phenylpropanolamine, and 1 Darvon) for an average of about eight requests per month. (We do not have figures at present for the other four participating hospitals.) As can be seen, almost 50% of the specimens were positive for the presence of drugs, which seems to indicate that the parents are able to guess fairly accurately when their children are using drugs.

### Information Supplied to Parents

Parents in Cobb County are given a list of county resources which can be approached for further help. This list includes acute detoxification and/or psychiatric resources, outpatient resources, longer-term inpatient and away-from-home resources, and self-help and other resource organizations. This list can also be obtained directly from the Cobb County Medical Society, P.O. Box 1208, Marietta, Georgia 30061; 404-428-2812.

### Endorsements

This program has been endorsed by a number of prominent citizens and organizations including George W. "Buddy" Darden, Representative U.S. Congress, 7th District (including Cobb County), the President of the Cobb County Bar Association (1985-1986), the Executive Director of PRIDE, the Juvenile Court Justices, and the Superintendents of Public Schools in Cobb County, and the City of Marietta. In addition, the Auxiliary to the Medical Association of Georgia, the Cobb County Board of Health and the Cobb County Board of Commissioners have endorsed the program. As mentioned earlier, the Medical Association of Georgia (Executive Committee and House of Delegates) has endorsed the program and has encouraged its component medical societies to involve themselves in similar programs. Lastly, the Georgia Psychiatric Association (Board of Trustees), the Georgia Council on Child and Adolescent Psychiatry, and the Georgia Society for Adolescent Psychiatry have endorsed the program, as have STRAIGHT, Inc., Atlanta, all six hospitals in Cobb County, the Cobb Area Pediatric Society, Mrs. Sue Rusche, Executive Director of Families-In-Action and, early in 1987, the Metropolitan Atlanta Council on Alcohol and Drugs, the 14th District of the Parent Teachers Association (which includes Cobb County), and the Georgia Legislature (Senate Resolution #10 and House Resolution #247 introduced respectively by Senator Roy Barnes and Representative Steve Thompson). We will continue to seek further endorsements.

### Publicity

A brochure describing the Program was prepared in the Fall of 1986, and about 15,000 copies had been distributed as of March, 1987. This brochure is being distributed also by two national parents' organizations, PRIDE and Families-In-Action. Some radio spots have been aired through efforts of local radio stations and the Cobb county Medical Society Auxiliary. A letter was sent by the MAG to the presidents of all of its component medical societies in June of 1986 encouraging them to start programs of their own.

### Goals

The MAG and the Cobb County Medical Society hope that other county medical societies will want to implement this program with the participation of their local hospitals. We also hope that having this service available will make prevention, diagnosis, and treatment of adolescent drug abuse easier. We feel that an adolescent urine drug screen program is not only a good public health measure, but also a good public relations activity on the part of county and state medical societies. For further information, contact Mrs. Camilla G. Taylor, Director of Medical Practice at the MAG office in Atlanta.

Knowing that urine drug screening is easily available should make a number of teenagers think harder before experimenting with drugs. Some adolescents, usually recovering adolescents, have in fact requested periodic urine drug screens to make it easier for them to save face when they say "no" to negative peer pressure. We hope that if a urine specimen comes back posi-

tive, the parent will want to continue monitoring that child's urine, preferably through the family physician, pediatrician, internist, psychiatrist, or addictionologist. Hopefully, this program will help parents seek therapy more quickly if they notice a combination of deteriorating behavior plus concrete evidence of drug abuse.

### Addendum

As of November, 1987 The Adolescent Urine Drug Screen Program has also received the backing of the Clayton County Medical Society which will be co-sponsoring the program with the Clayton County Parent Teacher's Association. It also is getting started in Fulton County under the auspices of the Medical Association of Atlanta at West Paces Ferry Hospital. Other hospitals in Fulton County have expressed interest also. Lastly, on September 2, 1987, the program was endorsed also by the Cobb County Pharmaceutical Association. ■


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# Poststreptococcal Acute Glomerulonephritis in Early County, 1982

Alan B. Bloch, M.D., M.P.H., J. David Smith, B.S., Richard R. Facklam, Ph.D., Thomas W. McKinley, M.P.H., R. Keith Sikes, D.V.M., M.P.H.

## Introduction

In 1934, Sutton mentioned an association of nephritis and impetigo or "so-called 'dew-boils' infection, which is frequent in the South."[1] In 1937, Yampolsky at Grady Hospital reported that approximately half of 21 patients with nephritis had impetigo preceding their illness.[2] In 1962, Blumberg, also at Grady Hospital, reported that 68 percent of 94 patients with acute glomerulonephritis seen over a 3-year period had impetiginous lesions.[3] An outbreak in a rural county in Georgia in 1982 offered another opportunity to investigate poststreptococcal acute glomerulonephritis (PSAGN) associated with impetigo.

## Methods

A case of PSAGN was defined as a patient with acute onset of hypertension and hematuria with clinical and/or laboratory evidence of Group A streptococcal (GAS) infection. Cases were identified by primary care physicians in the county. Admissions for acute glomerulonephritis of all etiologies to the Early Memorial Hospital from 1975 to 1982 were also reviewed.

Demographic data collected on PSAGN patients included age, sex, and race. Incidence rates of PSAGN in Early County by age, sex, and race were calculated using population data from the April 1980 U.S. census.

Physician and hospital records of all cases were reviewed in Early County and Dothan, Alabama, where patients were referred to a nephrologist, to determine clinical and laboratory findings, therapy, and clinical course. Attempts were made to identify epidemiologic links among identified cases of PSAGN.

Dr. Bloch is currently with the Division of Tuberculosis Control, Center for Prevention Services, Centers for Disease Control; Mr. Smith, Mr. McKinley, and Dr. Sikes are with the Office of Epidemiology, Division of Public Health, Georgia Dept. of Human Resources; Dr. Facklam is with the Laboratory Section, Respiratory Diseases Branch, Division of Bacterial Diseases, Center for Infectious Diseases, Centers for Disease Control.

Send reprint requests to Mr. Smith, Office of Epidemiology, 878 Peachtree St., Suite 210, Atlanta, GA 30309.

Wound and throat cultures were obtained on family contacts of recent PSAGN cases.

Because physicians in the county stated that there had been an increase in the number of cases of impetigo during the summer, a survey was done at Early County Elementary School to assess the prevalence by race and school grade of active skin lesions (sores and scabs) and healed skin lesions (scars) on the lower legs. Cultures were obtained from students with active lesions.

Available Group A streptococcal isolates from cases, family members of cases, and elementary school students were typed at the Streptococcus Reference Laboratory, Division of Bacterial Diseases, Centers for Disease Control.

Because residents of the county reported more mosquito bites in 1982 than in the previous year, mosquito-control workers in south Georgia were contacted to determine if there had been an increase over the previous year in the number of mosquito complaints.

Limited household surveys were

conducted on homes of patients with PSAGN to determine whether households had running water, the number of persons per household, and the number of rooms per house.

### Results

Primary care physicians reported a total of 10 cases of PSAGN in Early County with onset of disease from July to October 1982. Review of admissions of acute glomerulonephritis to the Early Memorial Hospital revealed that eight cases were admitted to the hospital in the first 10 months of 1982 (Figure 1). All of these cases were poststreptococcal in etiology. By comparison, in the period 1975 to 1981, there was an average of one case per year, a total of seven cases of glomerulonephritis of all etiologies for the entire 7 years) and a range of zero to four in any given year.

For the 10 cases of PSAGN in 1982, dates of hospital admission or initial physician visit ranged from July 24 to October 25. Most patients presented initially with a complaint of swelling of the face and legs of several days' duration. Of the 10 patients, six lived in Blakely, two lived outside the town limits of Blakely, one lived in Arlington, and one in Damascus. Patients ranged in age from 3 to 17 years, with a median of 7 years and a mean of 7.7 years. Two patients were less than 5 years of age, six were 5 to 9 years, one was 10-14 years, and one was 15-19 years. Six were male, and 4 were female; 9 were black, and 1 was white.

Table 1 gives incidence rates of PSAGN in Early County by age and sex and by age and race. Overall incidence of PSAGN in Early County was 0.8 cases per 1,000 population (1980 census population 13,158). The highest age-specific incidence rates were in 5 to 9-year-old children (4.9/1,000) and in <5-year-old children (1.8/1,000).

Incidence in males was 1.0 cases per 1,000 and in females was 0.6. The highest age-specific incidence in males was in 5 to 9-year-old children (8.1/1,000) and in females was in <5-year-old children (3.6/1,000). Incidence in nonwhites (1.6/1,000) was 16 times that in whites (0.1/1,000). The highest age-specific incidence was in 5 to 9-year-old children for both nonwhites (7.8/1,000) and whites (1.7/1,000).

### Medical Records Analysis

Physician and hospital records of all 10 cases were reviewed (Table 2). By definition, all 10 patients had clinical and/or laboratory evidence of GAS infection. Nine had skin lesions from several weeks to several months in duration. Almost all lesions were diagnosed as impetigo. These lesions were present on the lower extremities in nine patients and also occurred on the upper extremities and head in a few patients. Four had wound cultures positive for GAS. Five patients had a history of recent sore throat; one had a throat cuture positive for GAS. Three had elevated streptococcal antibody titers (antistreptolysin 0 or antistreptozyme).

By definition, all 10 patients had hypertension. The maximum diastolic blood pressure was 100-109 in three cases, 110-119 in five cases, 120-129 in one case, and 130-139 in one case.

By definition, all patients had hematuria. The maximum observed number of red blood cells per high-powered microscopic field was 10-19 in two patients, 20-29 in one patient, 40-49 in one patient, and "too numerous to count" in six patients. Of seven patients who had 24-hour urine collections analyzed for protein content, four (57 percent) had elevations (160 mg, 200 mg, 700 mg and 4900 mg).

Edema was present in eight patients and involved the lower extremities and the face. Of seven patients who had chest radiographs, five (71 percent) had abnormalities consistent with mild pulmonary congestion. Three of the nine patients lost 10 percent or more of their admission weight during hospitalization or afterwards. Only one patient had symptoms of pulmonary edema, including dyspnea, orthopnea, and rales; this was the only patient described as having anasarca. During hospitalization, he lost approximately 20 percent of his admission weight.

Hypocomplementemia was noted in all seven patients for whom this test was done. An elevated erythrocyte sedimentation rate was pres-

**TABLE 1 — Poststreptococcal Acute Glomerulonephritis Attack Rates* (Cases) by Age and Sex and by Age and Race, Early County, July to November 1982**

| Age | Number of Cases | Sex | | Race | | Total |
|---|---|---|---|---|---|---|
| | | Male | Female | White | Nonwhite | |
| < 5 | 2 | 0.0 | 3.6 (2) | 0.0 | 3.3 (2) | 1.8 (2) |
| 5-9 | 6 | 8.1 (5) | 1.6 (1) | 1.7 (1) | 7.8 (5) | 4.9 (6) |
| 10-14 | 1 | 1.5 (1) | 0.0 | 0.0 | 1.4 (1) | 0.7 (1) |
| 15-19 | 1 | 0.0 | 1.6 (1) | 0.0 | 1.5 (1) | 0.8 (1) |
| 20+ | 0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| All Ages | 10 | 1.0 (6) | 0.6 (4) | 0.1 (1) | 1.6 (9) | 0.8 (10) |

* Cases per 1,000 population. Number of cases in parentheses.

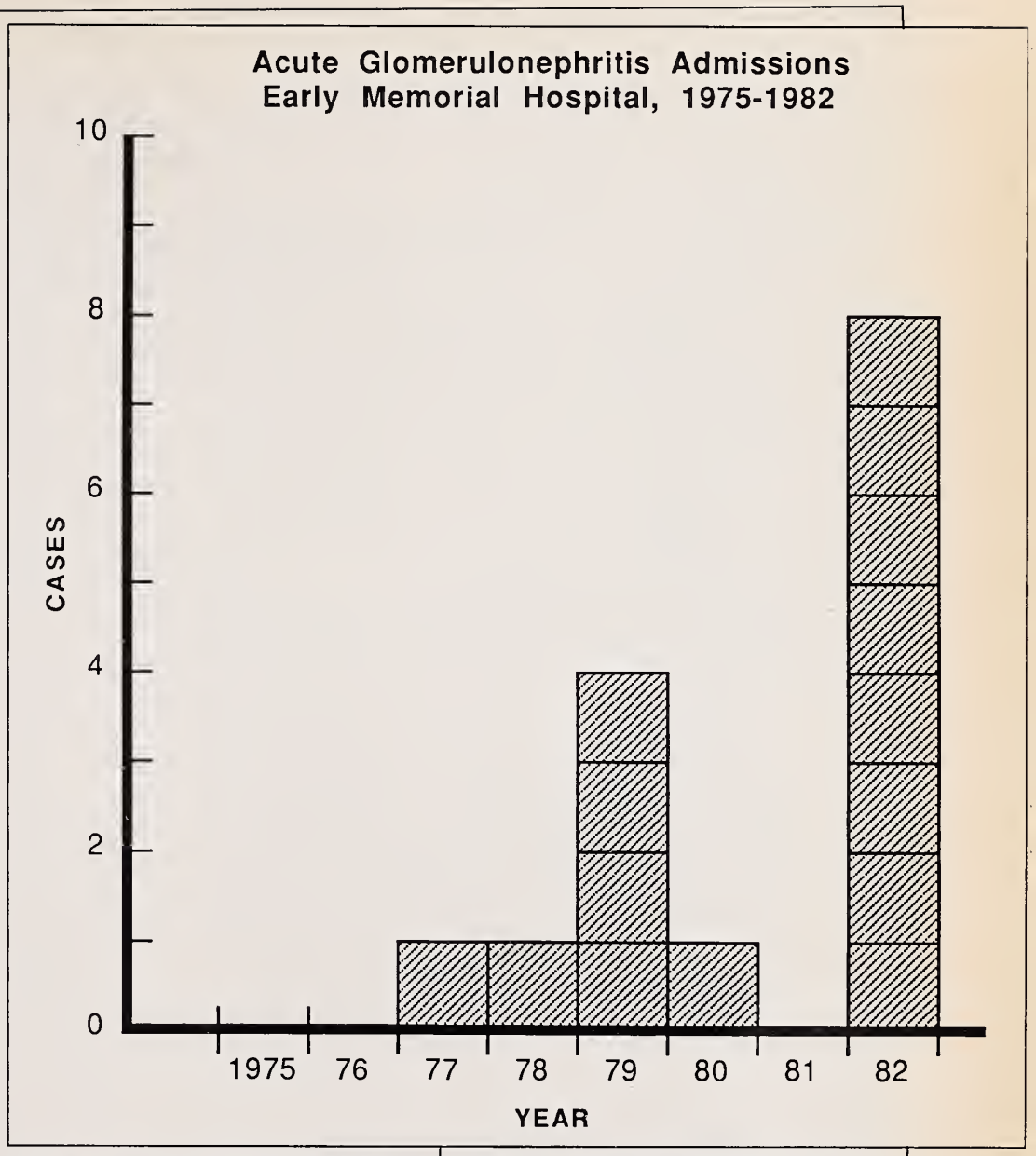
ent in six (75 percent) of the eight patients for whom this test was done. Four (40 percent) of the 10 patients had anemia as defined by a hematocrit less than 30 percent. Of the nine patients who had blood urea nitrogen (BUN) tests, three (33 percent) had elevations. These elevations were mild and ranged from 40 to 67 mg per 100 cc. Of the eight patients who had electrolyte measurements, only one had an abnormality, consisting of a brief potassium elevation to 6.2 milliequivalents per liter.

Of the 10 patients, 6 (60 percent) were referred to a nephrologist in Dothan, Alabama, for further evaluation and treatment. Nine of the patients were hospitalized in Early County or Dothan for a period ranging from 5 to 16 days for a median of 10 days and a mean of 9.7 days. Treatment included: systemic antibiotics for wound and throat infections, topical antibiotics for wound infections, antihypertensive medication, fluid restriction, salt restriction, protein restriction, and bed rest. None required dialysis.

As of September, 1983, all 10 patients were known to have had resolution of hypertension and hematuria. All three patients with mild BUN elevations have had resolution of azotemia. Epidemiologic links were established among only three of the cases of PSAGN. Two patients were siblings, and a third patient was a neighbor of these two. Wound cultures on these three patients were positive for GAS but were not available for typing.

### School Survey of Skin Lesions

Total enrollment at the Early County Elementary School was 1,244, including 734 (59 percent) blacks and 510 (41 percent) whites. The school included children from kindergarten through fifth grade, as well as children in special education. Half the classrooms in the school were surveyed; the classrooms were chosen in a nonrandom manner by selecting every other room on the school corridors.




Of the 1,244 students, 620 (50 percent) were examined. Of these 620 students, 403 (65 percent) were black and 217 (35 percent) were white (Table 3). Of these 620 students, 187 (30 percent) had lesions: 178 (29 percent) had scars, and nine (1 percent) had active lesions. Most of the active lesions were diagnosed as impetigo. Cultures of five students with active lesions were all positive for Group A streptococci. Of the 403 black students, 163 (40 percent) had lesions. Of the 217 white students, 24 (11 percent) had lesions. Thus, the prevalence in black students compared to white students was 3.7:1. The second grade had the highest prevalence of lesions; overall 47 percent (33/70) of the children had lesions, including 64 percent (28/44) of black children and 19 percent (5/26) of white children.

### Streptococcal Serotyping

Only one isolate from the PSAGN patients was available for typing: this patient's strain (wound) was GAS M-nontypable, T-11/12, SOR positive. A similar strain of GAS was isolated from an impetiginous lesion of a sibling; and an unrelated strain of GAS (M-12, T-12, SOR negative) was identified from another sibling. A relative of a second PSAGN patient was an asymptomatic throat carrier of a GAS strain (M-2, T-Imp 19, SOR positive). This same GAS strain was isolated from the skin lesions of two students in the school survey. Unrelated GAS strains (M-33, T-3/13, SOR negative

TABLE 2 — Clinical and Laboratory Findings in Confirmed Cases of Acute Glomerulonephritis, Early County, July-November 1982

| *Finding* | *Number Positive* | *Number Evaluated* | *Percentage Positive* |
|---|---|---|---|
| 1. Clinical or Laboratory Evidence of Group A Streptococcal (GAS) Infection | 10 | 10 | 100% |
| a. Skin lesions | 9 | 10 | 90% |
| b. GAS Positive Wound Cultures | 4 | 6 | 67% |
| c. GAS Positive Throat Cultures | 1 | 6 | 17% |
| d. GAS Positive Serology | 3 | 6 | 50% |
| 2. Hypertension | 10 | 10 | 100% |
| Maximum Diastolic | | | |
| a. 90-99 | 0 | 10 | 0% |
| b. 100-109 | 3 | 10 | 30% |
| c. 110-119 | 5 | 10 | 50% |
| d. 120-129 | 1 | 10 | 10% |
| e. 130-139 | 1 | 10 | 10% |
| f. 140+ | 0 | 10 | 0% |
| 3. Hematuria | 10 | 10 | 100% |
| Maximum Observed Red Blood Cells per High-Powered Microscopic Field | | | |
| a. 10-19 | 2 | 10 | 20% |
| b. 20-29 | 1 | 10 | 10% |
| c. 30-39 | 0 | 10 | 0% |
| d. 40-49 | 1 | 10 | 10% |
| e. "Too Numerous to Count" | 6 | 10 | 60% |
| 4. Edema | 8 | 10 | 80% |
| 5. Abnormal Chest X-ray | 5 | 7 | 71% |
| 6. Weight Loss ≥ 10% of Body Weight | 3 | 9 | 33% |
| 7. Hypocomplementemia | 7 | 7 | 100% |
| 8. Elevated Erythrocyte Sedimentation Rate | 6 | 8 | 75% |
| 9. Anemia | 4 | 10 | 40% |
| 10. Elevated Blood Urea Nitrogen | 3 | 9 | 33% |
| 11. Electrolyte Abnormality | 1 | 8 | 13% |
| 12. Proteinuria | 4 | 7 | 57% |

TABLE 3 — Early County Elementary School Survey* of Scars and Active Skin Lesions, November 5, 1982

| | *Percentage of Students with Skin Lesions* | | |
|---|---|---|---|
| *Grade* | *Black* | *White* | *Total* |
| K | 37% (30/81) | 12% (5/43) | 28% (35/124) |
| 1 | 38% (30/80) | 18% (5/28) | 32% (35/108) |
| 2 | 64% (28/44) | 19% (5/26) | 47% (33/70) |
| 3 | 36% (21/59) | 7% (3/41) | 24% (24/100) |
| 4 | 24% (14/58) | 3% (1/39) | 15% (15/97) |
| 5 | 61% (35/57) | 13% (5/39) | 42% (40/96) |
| Special Ed. | 21% (5/24) | 0% (0/1) | 20% (5/25) |
| Total | 40% (163/403) | 11% (24/217) | 30% (187/620) |

* Of 1,244 students enrolled, 59% (734) were black and 41% (510) were white. Of 620 students surveyed, 65% (403) were black and 35% (217) were white. Of 187 students with skin lesions, 87% (163) were black and 13% (24) were white. Site examined was the lower legs; 178 (29%) had scars and 9 (1%) had active lesions.

and M-nontypable, T-5/27/44, SOR positive) were isolated from skin lesions of two other students in the school survey.

## Environmental Assessment

Discussions with mosquito-control workers in Columbus and Albany indicated an increase in 1982 over 1981 in the number of mosquito complaints, suggesting that the mosquito population in southwest Georgia had increased, prob-

ably due to increased rainfall during the summer. Limited household surveys on patients with PSAGN indicated that all households had running water. There was a median of six persons per household, a median of five rooms per house, and a median of 1.2 persons per room.

### Recommendations

Recommendations by the state and county health departments during the outbreak included penicillin treatment of household contacts of recent PSAGN cases concurrent with penicillin treatment of those cases. Students in the school survey identified as having active skin lesions were referred for antibiotic treatment. It was also recommended that the remaining students in the county schools be screened for active skin lesions and that students with such lesions be referred for treatment.

### Discussion

The predominance of PSAGN cases among young children in Early County is similar to findings in other studies. The male predominance of PSAGN has been noted in some series but not in others. Although the predominance of PSAGN among blacks has been noted previously, some authors have suggested that this merely reflects the racial distribution of the population. The incidence rate among nonwhites in Early County was 16-fold that of whites, indicating a real difference in rate in the black population. Skin lesions in the survey at the Early County Elementary School were also predominantly in black children.

As was observed in this outbreak, PSAGN has a seasonal peak in the summer and early fall. Blumberg observed that the peak occurrence of PSAGN coincided with the peak occurrence of impetigo.[3]

The clustering of two cases in one household among the Early County cases is consistent with previous observations that multiple cases can occur in households. In an outbreak in Trinidad involving 720 patients, multiple cases occurred in 47 households.[5]

Most patients present with a chief complaint of "swelling." It is uncommon for patients to seek medical care first for the impetigo, which precedes the symptoms of acute glomerulonephritis. In a patient with acute glomerulonephritis, "even in the absence of bacteriologic isolation of streptococci, the presence of skin lesions morphologically compatible with streptococcal impetigo is highly suggestive" of a streptococcal etiology.[4]

Skin invasion by streptococci is often preceded or accompanied by some local break in the skin, such as trauma due to insect bites or minor abrasions. In 1982, the mosquito population in southwest Georgia was believed to be larger than usual because of the abundant rainfall during the summer. Also supporting an increased mosquito population in Georgia in 1982 was a dramatic increase in human and equine arboviral encephalitis cases.[6] During summer and early fall, children are more likely to wear short pants and go barefoot, exposing skin on the lower extremities to insect bites, cuts, and abrasions. Crowding is also mentioned as a risk factor for impetigo. The median of 1.2 persons per room in the households of PSAGN cases is much higher than the median of 0.5 for both Early County and the entire state of Georgia.

Because a GAS isolate was available for serotyping on only one PSAGN case, it cannot be determined whether a single streptococcal serotype was responsible for all PSAGN cases. This one available isolate from a PSAGN patient was nontypable by the M serotype. A sibling had an M-12, T-12 strain which is the classic serotype associated with PSAGN after pharyngitis or tonsillitis. A sibling of another case, as well as two persons with impetigo in the elementary school, had serotype M-2, T-Imp 19 which has been associated with PSAGN related to impetigo.[7]

Although certain serotypes have been implicated in PSAGN outbreaks as being highly nephritogenic,[8] it has not been established that any serotype does not have nephritogenic potential.[9] Data on file at the Streptococcus Reference Laboratory, CDC, for an 8-year period (1973-1980) include a wide distribution of M and T types of GAS associated with PSAGN. Fourteen M-types and 21 different T-types of GAS were identified among 191 specimens submitted to the Reference Laboratory for typing, with information implying the isolates were associated with AGN.[9] Both M-nontypable, T-12, and M-2, T-Imp 19 strains of GAS are included in the above summary.

Treatment of impetigo with penicillin is part of good medical care. However, there is no evidence that such treatment modifies the course in a patient with preexistent PSAGN or that such treatment aborts the disease in a person who is within the latent period.[4] Nevertheless, penicillin is effective in epidemiologic efforts to eliminate nephritogenic strains by treating PSAGN patients and their family contacts.

Prognosis for PSAGN in children is excellent. Patients generally have resolution of hypertension, edema, hypocomplementemia, and azotemia within several weeks. However, microscopic hematuria may persist for months despite the fact that patients regain a sense of general well being. Mortality is rare and progression to severe irreversible renal failure occurs perhaps in <1 percent.[4] A 10-year follow up of 61 patients in an epidemic in Red Lake, Minnesota, showed that no cases progressed to chronic glomerulonephritis.[10] A 2 to 6-year follow up of 760 Trinidadians who had PSAGN showed a prevalence of urine abnormalities and hypertension consistent with background prevalence of a normal population.[11]

### Acknowledgments

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# AMBULANCE SERVICES IN GEORGIA 1982-1985

Thomas W. McKinley, M.P.H., R. Keith Sikes, D.V.M., M.P.H.,
Dallas P. Jankowski, J.D.

**Abstract**

*Ambulance transports in Georgia increased from 33.6 per 1,000 population in 1982 to 45.1 per 1,000 population in 1985. Analysis of a stratified, systematic sample of ambulance trip reports during this period revealed that transport rates increased at a higher rate among persons 75+ years of age (the fastest growing segment of the state population) than among other age groups. Transport rates were higher among males than females and appeared to have increased more rapidly among blacks than whites during the 1982-1985 period. Trauma accounted for approximately 40% of all transports; 44% of these trauma transports were due to motor vehicle injuries and 21% to falls, about half of which occurred at home. Approximately 15% of all transports were for patients whose condition was classified as severe, 54% as moderate, and 31% as minor. Response time from the time of call to arrival at the scene was under 9 minutes for approximately 65% of all ambulance transports.*

## Introduction

The Georgia Emergency Medical Services Act of 1972 authorized the Georgia Department of Human Resources (DHR) to adopt rules and regulations regarding licensing of ambulance services and training and certification of emergency medical technicians in the state. The Federal Emergency Medical Services Act of 1973 (Public Law 93-154) authorized federal grants to offset up to 75% of the cost of establishing and operating emergency medical services systems the first year and up to 50% the second year. These two pieces of legislation combined to transform emergency medical services (EMS) in Georgia from a system of inadequately equipped, poorly designed, vehicles operated by essentially untrained attendants whose major skill was rapid transport into a system of well equipped, modern vehicles staffed by licensed technicians trained in basic or advanced life support.

Currently, there are 230 licensed ambulance services in Georgia. Of this number, 173 are public, 54 private (40 commercial, six funeral homes, eight private hospitals), and three industrial (personal communication with Mr. Bill Hammett, Emergency Health Section, Division of Public Health, Georgia DHR, April 1, 1987). Ambulance services are either located and operated in or are under contract in all counties in the state except seven (Baker, Chattahoochee, Echols, Glascock, Long, Montgomery, and Taliaferro) (Figure 1). To operate

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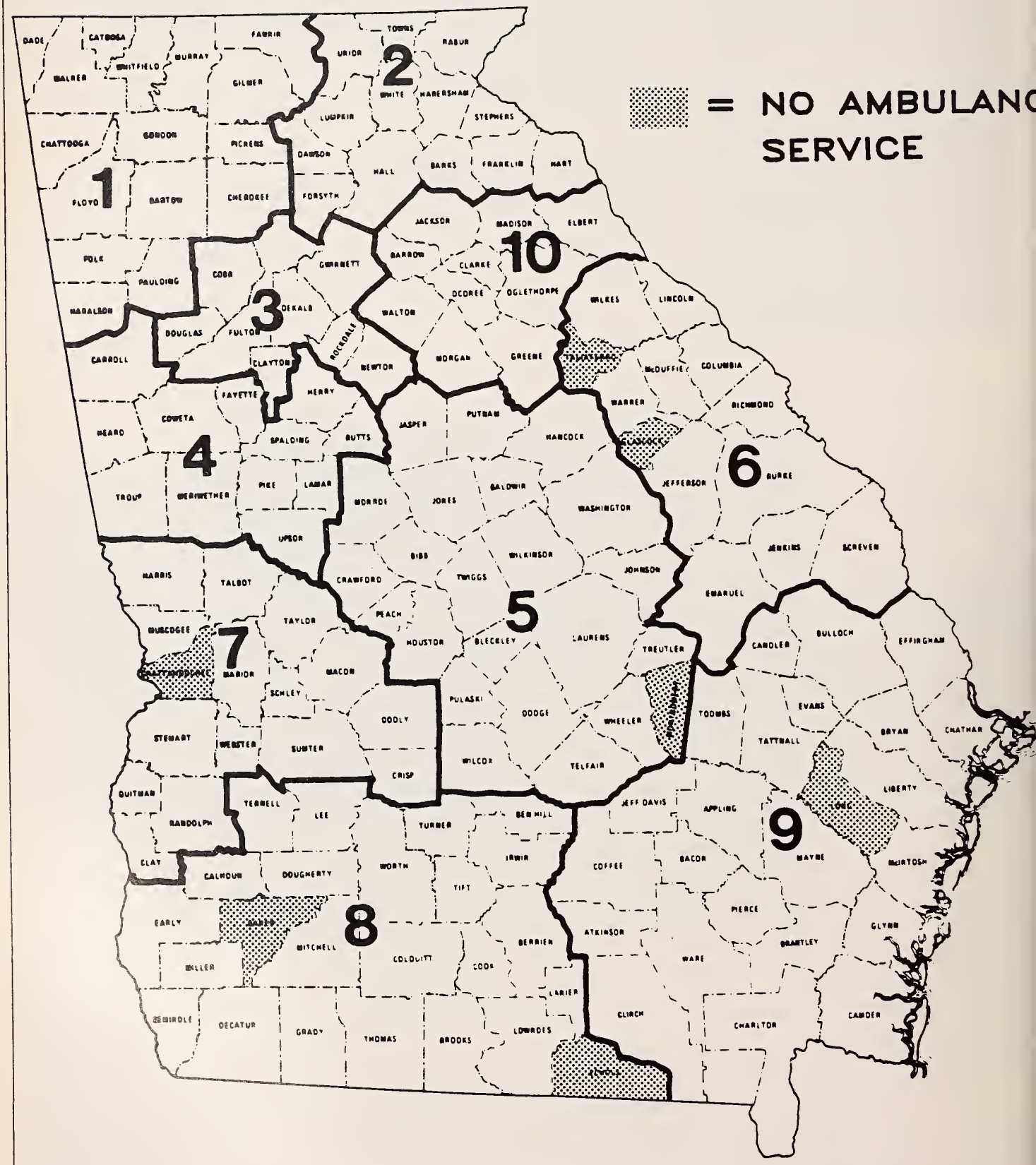
Figure 1

# EMS AND DHR REGIONS STATE OF GEORGIA



these ambulance services, Georgia has 4,900 certified emergency medical technicians (EMTs); 2,419 (47%) certified at the basic level, 1,688 (35%) at the advanced level, and 793 (16%) at the cardiac technician level.

Under current regulations, ambulance services are required to complete a standard trip report form for every transport. During the 4-year period 1982-1985, there were 935,287 ambulance transports in Georgia (personnel communication with Mr. Bill Hammett, Emergency Health Section, Division of Public Health, Georgia DHR, December 1986). This paper provides a descriptive analysis based on a sample of these trip reports.

## Methods

Georgia is divided into 10 EMS regions, each with an EMS coordinator, which coincide with DHR districts (Figure 1). Copies of all local trip reports were sent monthly to the respective regional coordinators, who systematically sampled each nth form (e.g., every 25th, every 43rd, etc.). The sampling interval was determined for a finite population using the total number of trip reports from the previous year for each region as the expected and calculating the number of forms needed in the sample to detect a 10% difference with 95% confidence.

Sampled forms were forwarded to the Emergency Medical Services Section, Division of Public Health, DHR, for review and data entry. A total of 15,234 EMS trip report forms were included in the samples during the 4-year period 1982-1985. Data were processed on State mainframe computers using the Statistical Package for Social Services (SPSS).

## Results

Ambulance transports in Georgia increased from 33.6 per 1,000 population in 1982 to 45.1 per 1,000 in 1985 (Figure 2). Region 1 had the lowest transport rates during 3 of the 4 years, ranging from 20-26 per 1,000 population. Transports were highest each year in Region 3, ranging from 42-64 per 1,000.

Figure 2
EMS TRANSPORTS PER 1,000 POPULATION
GEORGIA, 1982–1985

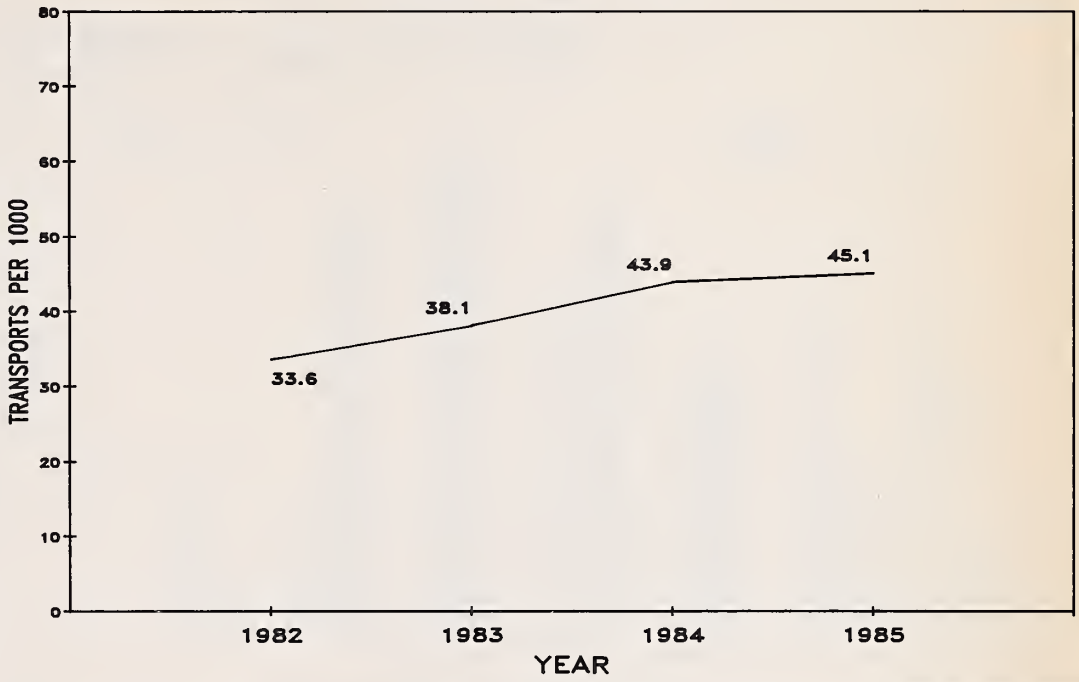
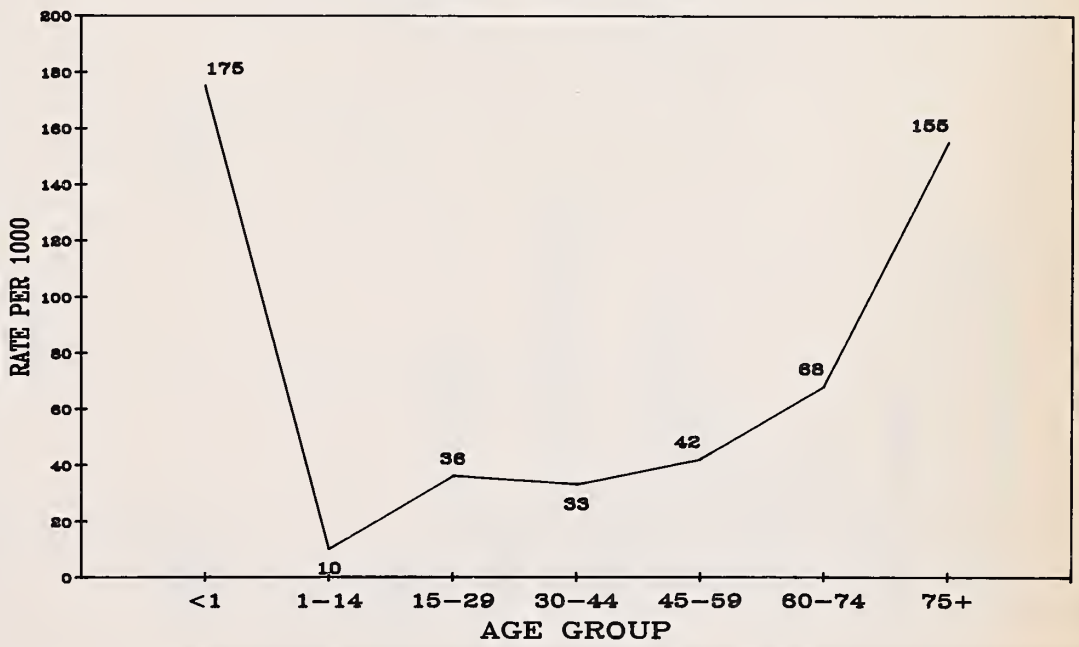



Figure 3
EMS TRANSPORTS PER 1,000 POPULATION BY AGE GROUP
GEORGIA, 1982–1985



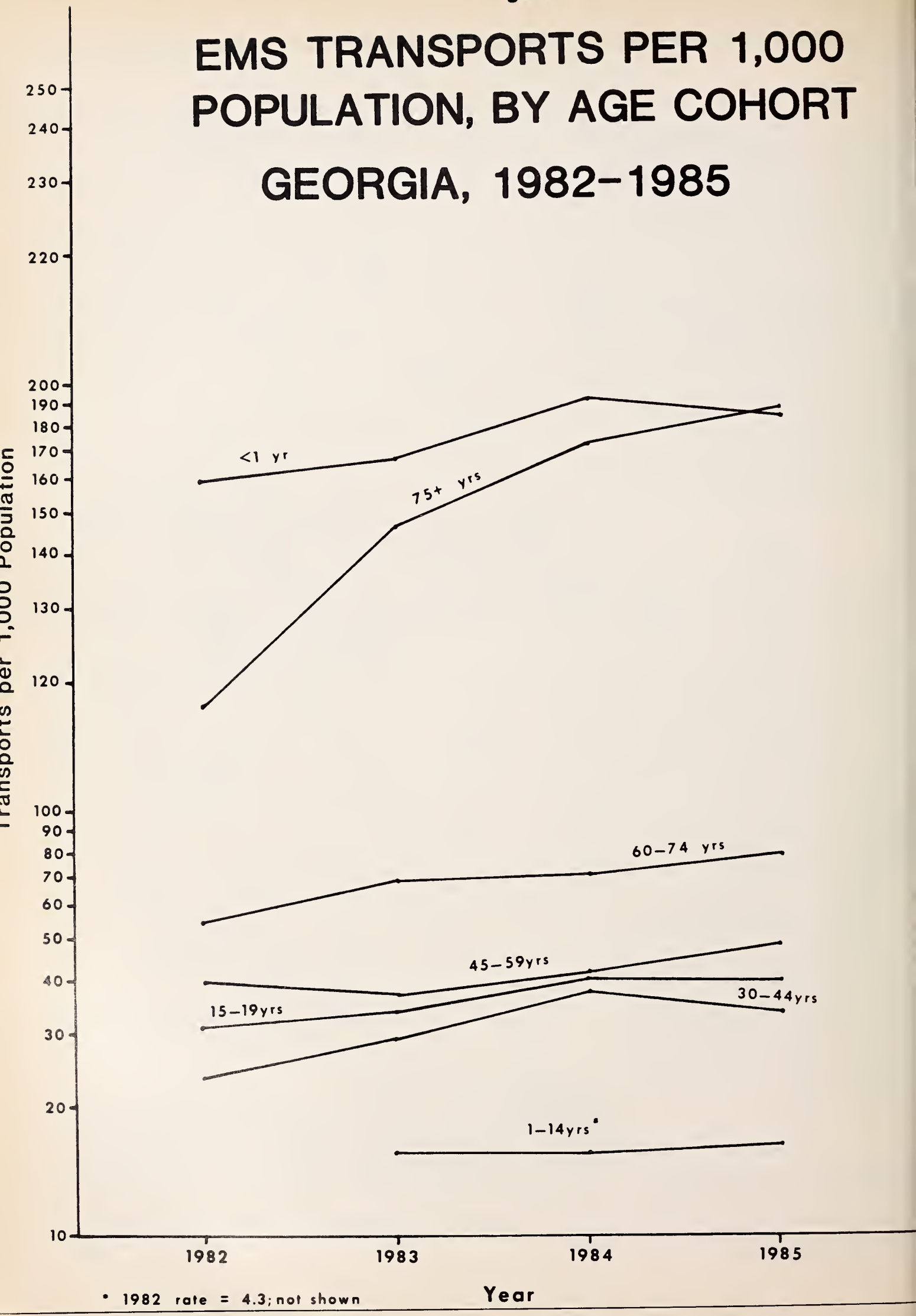

## Age

The highest ambulance use rates occurred at the extremes of life (Figure 3). The transport rate per 1,000 persons increased among infants under 1 year of age during 1982-1984 but leveled off between

Figure 4

# EMS TRANSPORTS PER 1,000 POPULATION, BY AGE COHORT

## GEORGIA, 1982-1985




* 1982 rate = 4.3; not shown

1984-1985. The most pronounced increase during the 4-year period occurred among persons in the 75+ age group (Figure 4).

The proportion of EMS transports was significantly higher ($p<0.05$, Z test) in all 4 years for age groups <1, 60-74, and 75+ than their proportion in the population. Conversely, EMS transports were significantly lower than their proportion in the population in all 4 years for age group 1-14 and in 3 of 4 years for age group 30-44. Transports among age groups 15-29 and 45-59 more closely approximated their proportion in the population (Figure 5).

### Race

Transport rates for blacks and whites were not significantly different from their respective proportions in the population in 1982 and 1983. However, rates increased more rapidly in blacks than whites during the 4 year period. As a result, blacks were being transported at a significantly higher rate than their proportion in the population ($p<0.05$; Z test) both in 1984 and 1985 (Table 1).

### Sex

The transport rate for males was significantly higher than their proportion in the population in every year except 1984, when transport rates for both males and females closely approximated their respective proportions in the population (Table 1).

### Trauma

Approximately 40% of all EMS transports were for injuries. The highest number of injury transports was due to motor vehicles, followed by falls. Together these two causes accounted for approximately 65% of all injury transports. Impact, cutting, inhalation/ingestion, firearms/explosions, and burns accounted for another 13-18% of injury transports (Table 2). Data for 1983-1985 indicated that more than 50% of transports for falls and firearms originated at home.

FIGURE 5
AGE DISTRIBUTION OF EMS TRANSPORTS AND STATE POPULATION
GEORGIA, 1982–1985

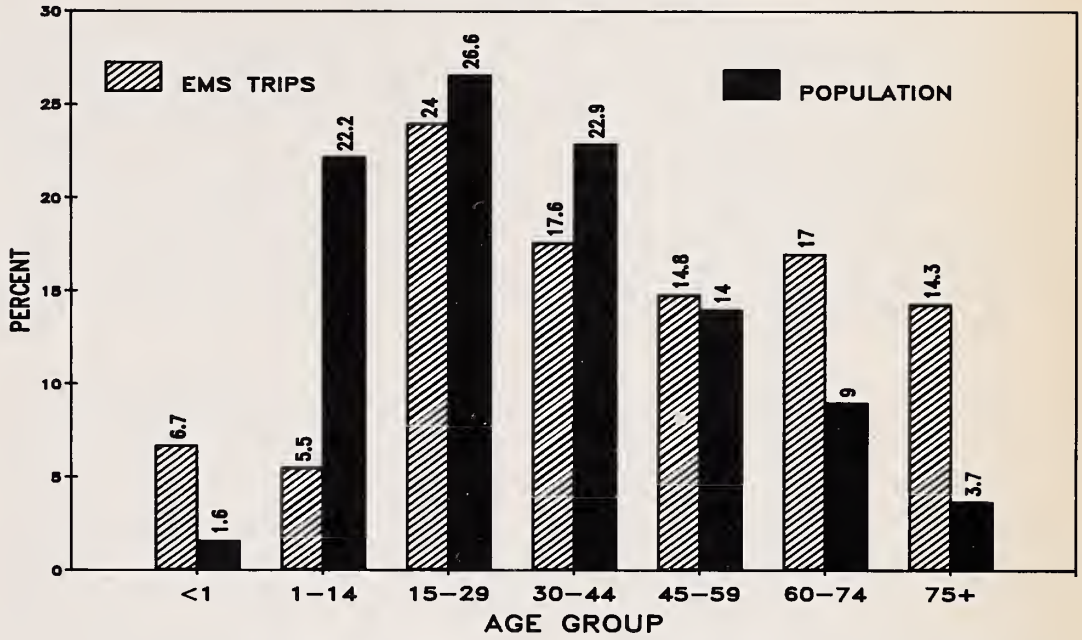
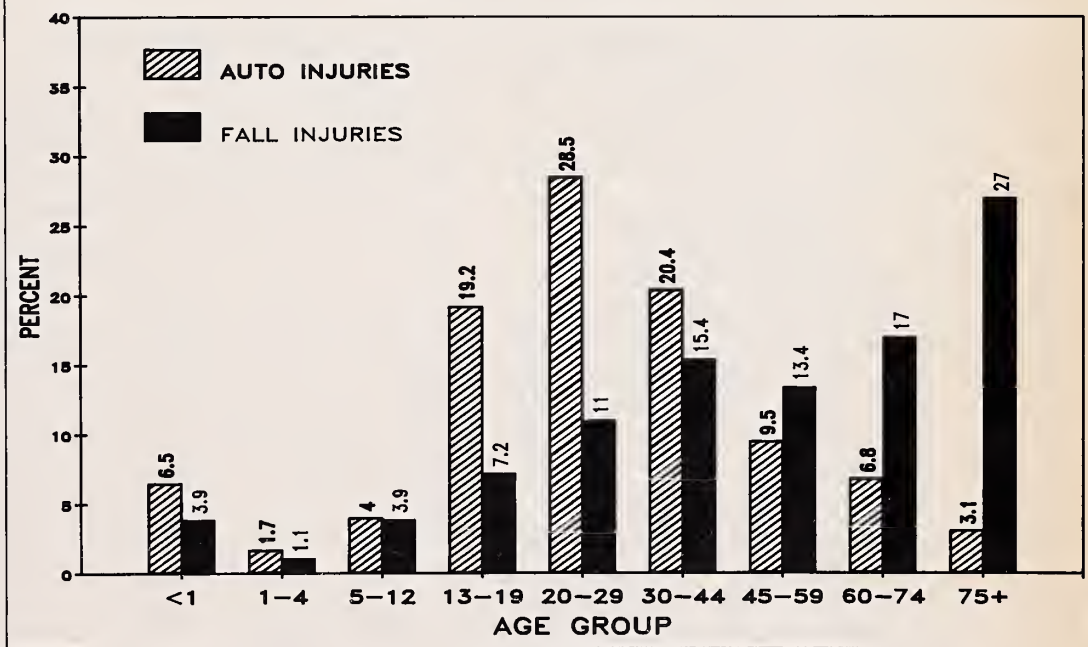



Figure 6
AGE DISTRIBUTION OF TRANSPORTED PERSONS BY TYPE OF INJURY
GEORGIA, 1982–1985




Automobile injury transports peaked in the age group 20-29 years. Fall injury transports generally increased with age and rose exponentially in the 75+ year age group (Figure 6).

### Severity

During the 4-year period, approximately 15% of transports overall (range 15-17%) were for patients whose condition was judged by EMTs to be "severe," 54% (range

**ABLE 1 — Estimated Transport Rates Per 1,000, by Race and Sex, Georgia, 1982-1985**

| | Race | | | Sex | | |
|---|---|---|---|---|---|---|
| ar | Black | White | B/W Ratio | Male | Female | M/F Ratio |
| 32 | 31.4 | 34.4 | 0.91 | 36.2 | 31.1 | 1.16* |
| 33 | 41.8 | 36.5 | 1.15 | 41.0 | 35.4 | 1.16* |
| 34 | 64.5 | 35.7 | 1.81* | 42.4 | 45.4 | 0.93 |
| 35 | 58.9 | 39.5 | 1.49* | 49.6 | 40.8 | 1.22* |

<0.05; Z test
e: N = 15,234 trip reports
Race data excludes 1,097 unknowns (7.2% of the total)
Sex data excludes 766 unknowns (5.0% of the total)

**TABLE 2 — Percent of Injury Transports, by Type of Injury, Georgia, 1982-1985**

| | Percent | | | |
|---|---|---|---|---|
| e Injury | 1982 | 1983 | 1984 | 1985 |
| tor Vehicle | 44.3 | 42.1 | 45.1 | 43.0 |
| ls | 20.9 | 27.1 | 17.3 | 19.5 |
| act | 5.7 | 5.2 | 6.9 | 6.5 |
| ting | 5.3 | 4.3 | 5.0 | 4.5 |
| alation/Ingestion | 3.6 | 3.1 | 5.1 | 3.5 |
| earms/Explosion | 1.5 | 2.4 | 2.6 | 4.0 |
| n | 1.5 | 1.0 | 1.9 | 1.5 |
| ry Transports | N=1,511 | N=1,458 | N=1,829 | N=1,420 |

51-56%) were for patients whose condition was labelled as "moderate," and 31% (range 29-32%) whose condition was "minor."

### Response Time

During the 4-year period, approximately 65% of ambulance trips had a response time under 9 minutes from time of call to time of arrival at the scene. Data were similar for all years; there was no indication of a trend toward reducing or increasing response time.

Trip reports from 1984, labelled "emergency," were stratified by type of illness (cardiac arrest, injury, or general) and compared for response time. The proportion of responses under 4 minutes was not significantly different for the three illness groups; 16.3% of cardiac arrest responses were under 4 minutes, 18.6% of injury responses, and 19.0% of general illness responses.

### Discussion

Ambulance transports in Georgia increased more rapidly than the state population during the 4-year period under analysis. Results of a recent survey of ambulance services in the state indicated that this trend is expected to continue at least through 1990.[1] Increases in use are not uniformly distributed in the population. Use rates are growing more rapidly among blacks than whites and among persons 75 years of age and above than other age groups. Not only are use rates increasing in the 75+ age group, this age group is the fastest growing segment of the state population.[2]

The estimated expenditure for ambulance services in Georgia in 1985 was $48,827,000. Expenditures are projected to increase more than 90% by 1990.[1] This escalation in cost is certain to bring mounting pressure to evaluate both the appropriateness of ambulance use and quality of care in terms of patient outcome. Approximately 31% of ambulance transports in Georgia were for conditions of minor severity. Inappropriate use of ambulance services has been observed elsewhere.[3] More study is needed to determine the appropriateness of ambulance use in Georgia involving cases of minor severity.

Response times of less than 9 minutes have been shown to be associated with increased survival rates in potentially life-threatening emergency cases.[4] In cases of cardiac arrest, survival rates are higher where response times are under 4 minutes. While approximately 65% of ambulance responses in Georgia were under 9 minutes, only about 16% were under 4 minutes for patients with cardiac arrest. Data for 1982-1985 gave no indication of a trend toward decreasing response time. Therefore, it seems unlikely that the overall response rate will improve significantly in Georgia during the next few years.

***Approximately 15% of transports involved patients whose condition was severe, 54% whose condition was moderate, and 31% whose condition was minor.***

The ambulance trip report form in current use has space for recording positive or negative changes in patient condition, both at the scene and en route. However, these data are much too crude to provide meaningful results regarding quality of care. A revised ambulance trip report form which emphasizes assessment of patient condition was implemented by the State Emergency Health Section on January 1,

1987. Ideally, the new form should be linked to motor vehicle accident reports, emergency room records, and hospital records in order to evaluate patient outcome.

***Continued expansion of ambulance services in Georgia is projected through 1990.***

### Summary and Conclusions

Analysis of a stratified, systematic sample of ambulance trip reports in Georgia for the 4-year period 1982-1985 revealed the following:

1. Ambulance transport rates increased more rapidly than the population (1982 = 33.6/1000 population; 1985 = 45.1/1000 population).
2. Transport rates increased more rapidly among persons 75+ years of age (the fastest growing segment of the state population) than among other age groups.
3. Transport rates were higher among males than females and appeared to be increasing more rapidly among blacks than whites.
4. Trauma accounted for approximately 40% of all transports; 44% of these trauma transports were due to motor vehicle injuries and 21% were due to falls, of which about 50% occurred at home.
5. Approximately 15% of transports involved patients whose condition was severe, 54% whose condition was moderate, and 31% whose condition was minor.
6. Approximately 65% of all ambulance responses were under 9 minutes.

Continued expansion of ambulance services in Georgia is projected through 1990. This expansion will be associated with a rapid increase in cost which will undoubtedly lead to mounting pressure to evaluate both appropriateness of use and the effect on patient outcome. To accomplish the latter evaluation, ambulance trip reports need to be linked with motor vehicle accident reports, emergency room records, and hospital records.

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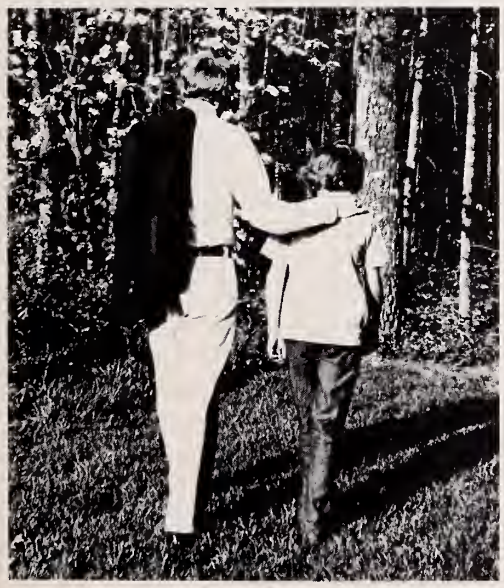

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# Locally Advanced Carcinoma of the Breast

*Erich G. Randolph, M.D.*

***"Inflammatory carcinoma should be considered a disseminated disease process at the time of diagnosis even if no clinical evidence of metastases exists."***

In the management of breast cancer, a great deal of attention has been given by both the public and medical media to conservative therapy (lumpectomy with axillary dissection followed by radiation) for early $T_1$ & $T_2$ breast cancer patients. Probably because of the historically dismal prognosis associated with it, inflammatory breast cancer and the locally advanced stages, $T_3$ & $T_4$, are not typically spotlighted. The management approach to these patients is extremely important, because women still present with advanced disease even with the increased public awareness about early detection.

Inflammatory breast cancer is a clinical diagnosis characterized by erythema, rubor, peau d' orange, edema, and wheals or ridges. Typically, the average age of these patients is 56 years. Although inflammatory cancer is labeled a clinical diagnosis, we must be cautious to manage those patients with the histopathologic description of dermal lymphatic invasion as the patient with "classical inflammatory cancer."

The survival results in the management of inflammatory breast cancer have been poor using either surgery or radiation. Surgery alone or in conjunction with radiation provides moderate local control with rates in the range of 50-75%.[1] In 80% of the patients, however, distant metastases develop by 12 months, and over 90% are dead by 24 months.[2] These statistics have led most physicians to recognize that inflammatory carcinoma should be considered a disseminated disease process at the time of diagnosis even if no clinical evidence of metastases exists. This has shifted the emphasis of treatment to the realm of aggressive chemotherapy regimens. Such a regimen has been shown to be effective with the use of adriamycin-based treatments [Florouracil, Adriamycin, Cytoxin(FAC); Vincristine, Adriamycin, Cytoxin(VAC)].

Adriamycin-based regimens have been shown to provide increased disease-free survivals (45% at 5 years for $T_3$ & $T_4$ locally advanced)[3] and increased overall survivals in inflammatory and locally advanced $T_3$ & $T_4$. The best survival results are seen in those patients in whom there is no histopathologic evidence of residual disease after mastectomy. Disease-free survival rates of greater than 75% at 5 years have been reported, as opposed to 30%

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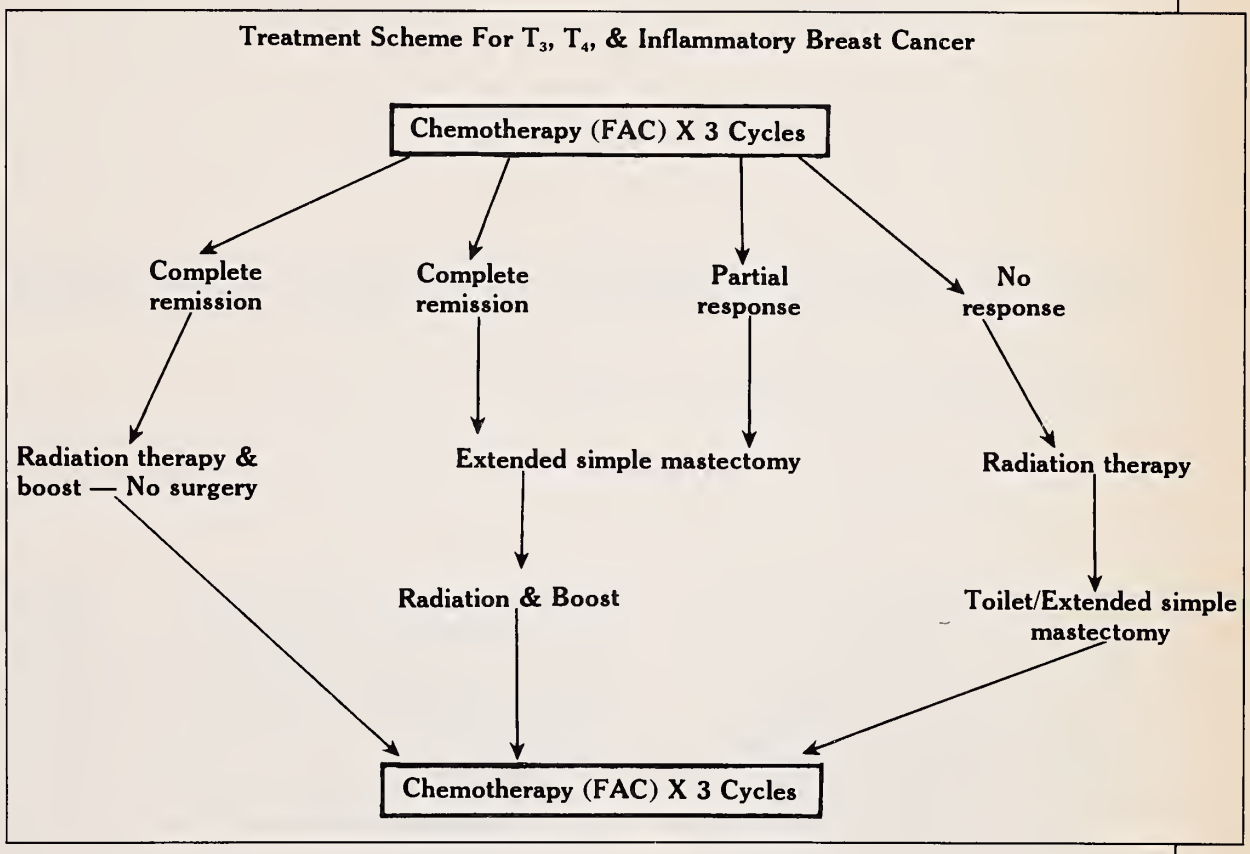


in patients with gross residual disease.[4] Although there is an improvement in these parameters, local regional control with chemotherapy alone is not improved. For this reason, a combined modality approach using chemotherapy, radiation therapy, and surgery is essential. The addition of radiation and surgery improve local-regional control.[5] Typically, the chemotherapy is given as the first phase of treatment; however, the optimal sequence of the treatments has yet to be determined. After chemotherapy, depending on whether the patient has a complete, partial, or no response, the patient will undergo surgery followed by radiotherapy (see chart).

Morbidity in this combined approach can be minimized by the surgical and radiotherapeutic arms of treatment. The surgery need be no more than either a simple or extended simple mastectomy, because a modified radical does not add to survival or local control but does increase morbidity. High dose radiotherapy using doses greater than 8000 rads utilizing the Baclesse technique is not indicated in this combined approach. Doses in the range of 5000-5500 rads delivered over 4-5 weeks significantly minimizes skin reaction, fibrosis, or ulceration. Using high energy electrons (12 MEV to 15 MEV) allows optimal treatment of the internal mammary lymph nodes without exposing the heart to toxic doses of radiation. This is extremely important in patients who have already received adriamycin.

More work needs to be done to further improve the survival results; however, the dismal prognosis of inflammatory and locally advanced $T_3$ & $T_4$ breast cancer has been improved. In step with improvement, evaluation by the surgeon, radiation therapist, and medical oncologist at the onset of treatment is essential. This approach prior to starting any treatment will provide the patient with both optimal quality of life and improved survival with minimization of morbidity.

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# New Inotropic Drugs: Amrinone and Milrinone

*Jimmy V. Lemke, B.S., M.B.A., SC (ASCP)*

## History

The drugs in the class, bipyridine, are the latest compounds considered for the treatment of cardiac failure. They represent an attempt to avoid the complications associated with digitalis and provide positive inotropic effect while minimizing the increase in heart rate and, thus, $O_2$ demand of the myocardium.

Within this class are amrinone and milrinone. Amrinone was first evaluated as a bronchodilator for the treatment of asthma. Evaluations of its effects on the heart demonstrated that amrinone differed from the cardiac glycosides, the sympathomimetic amides and, possibly methylzanthines in that it was a positive inotropic agent with vasodilator properties and had minimal effect on heart rate. Milrinone represents an effort to reduce the side effects associated with amrinone. A methyl group on carbon-3 was added to amrinone, under the assumption that the C-3 carbon was interacting with sulfhydral groups, producing thrombocytopenia and hepatotoxicity.

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This paper was sponsored by the Georgia Affiliate of the American Heart Association. Contributions to this Section should be sent to Wesley Covitz, M.D., HEART Section Editor, and Professor of Pediatrics, Section of Pediatric Cardiology, Medical College of Georgia, Augusta, GA 30912. Send requests for reprints for Mr. Lemke's article to Dr. Covitz.

## Method of action

Research by Binah and associates showed that the bipyridines did not augment cardiac function in the same manner as standard drugs used for the treatment of heart failure.[1] No adrenergic receptor effect or inhibition of the NaK ATPase pump was noted. Rather, the bipyridines work through the inhibition of phosphodiesterase activity in the myocardium. The cardiac enzyme that is inhibited is in the adenosine 3′,5′monophosphate (cAMP) phosphodiesterase (PDE), specifically PDE III. PDE is a membrane-associated enzyme which has a high specificity for cAMP and catalyzes the conversion of cAMP to 5-AMP.[2] By inhibiting this enzyme, there is a net increase in the level of circulating intracellular cAMP. This increase in the levels of cAMP modulates myocardial contractility at the intracellular level through the activation of cAMP dependent protein kinases which induce phosphorylation reactions.

While the bipyridine compounds have a positive inotropic effect on adult myocardium, Binah, et al. demonstrated a reduction in the peak tension generated when neonatal canine cardiac muscle was exposed to amrinone.[2] This effect tends to be reversed by the third day of life, and an increasingly positive inotropic effect occurs for the first 100 days of life. The T-tubule system is underdeveloped in the newborn and may develop as late as 3 months after birth.[1] It is also noted that in adult tissues with poorly developed T-tubules, such as Purkinje cells and the atrium, there is minimal or no response to amrinone. This supports the theory that amrinone works at the level of the T-tubules. While amrinone has a negative effect during the newborn period, milrinone was found to have a positive inotropic effect in the neonatal myocardium and to be 20 to 30 times more potent than amrinone.[2,3] No explanation for this variation has been offered.

The bipyridines also have a large vasodilator effect. Vascular smooth muscle has a marked responsiveness to changes in cytoplasmic ionized calcium levels.[4] Amrinone may be acting by a mechanism that is distinct from

the increase in intracellular cAMP concentrations, but the mechanism has eluded researchers thus far. Whatever the mechanism is, there is the ability to cause direct vasodilation in the systemic arteriolar and venous systems. Similar effects on the pulmonary side have also been demonstrated.[5]

### Clinical Pharmacology

In clinical trials, amrinone and milrinone, given by either oral or IV administration, have been found to have sustantial hemodynamic benefit without evidence of accelerated progression of the underlying heart failure.[6-9] The oral form of amrinone was found to cause severe GI side effects, hepatotoxicity, and increase the risk of cardiac arrhythmias so that it was withdrawn from clinical trials. Conrad and his associates demonstrated that milrinone produces a significantly greater reduction in ventricular filling pressure than is demonstrated by dobutamine and, that it has a hemodynamic response equivalent to that of nitroprusside with significantly less attendant hypotension.[10, 11]

Edelson and associates extensively evaluated the pharmacokinetics of amrinone and milrinone using double blind studies for oral and IV routes of administration.[12] An open two compartment model was demonstrated for these drugs. In normal volunteers, milrinone was found to have a half-life of 0.8 hr. In patients, the half-life was much longer than that of volunteers, 2.3 hr for IV and 2.7 hr for the oral. In evaluating clinical efficacy, Monrad found a significant increase in peak responses in cardiac index and pulmonary capillary wedge pressure with both short and long term (1 month) trials of milrinone.

***"Milrinone is about 20 to 30 times as potent as amrinone . . . (and) differs from amrinone in that the inotropic response is accompanied with a slight increase in heart rate."***

Amrinone was found to have similar half-life characteristics with a half-life of 3.8 hr in volunteers. Again, there was a disparity seen in patients, the half-life of amrinone ranging from 5.0 to 8.3 hr (average 6.6 hr).

Monrad and his associates thought that this difference might be the effect of reduced perfusion of the liver and kidney or as the result of another drug being taken by the patients.[11] Patients were re-evaluated after 1 month of therapy. The differences in half-life persisted, so improved hemodynamics did not seem to effect this discrepancy. It may be that there is no need to adjust the dose regimen with improvement of hemodynamic status.

Plasma levels of amrinone have correlated well with an increase in cardiac index.[13] A plasma amrinone level of approximately 4 μg/ml correlates with a 50% increase in cardiac index. The current recommended dosing schedule is:

1. Initial IV bolus of 0.75 mg/kg over 3-5 minutes.
2. A second equal dose 30 minutes later, if necessary.
3. Initial dose should be followed with a continuous infusion of 5-10 μ/kg/min.

At an infusion rate of 5 μg/kg/min, the steady state plasma level is near 2 μg/ml and is associated with a 20% increase in cardiac output. Doubling the infusion rate to 10 μg/kg/min increases the

plasma steady state level to about 10 μg/ml and increases cardiac output by 50%. With a bolus, amrinone plasma levels peak in 2 minutes. Improvement in cardiac output lasts for approximately 60 minutes, and pulmonary capillary wedge pressure is reduced for as long as 90 minutes, if the drug is started without an initial bolus, effects are seen in 20-60 minutes, and the peak plasma level occurs at 7 hours. In general, a 30-60% increase in cardiac output can be seen in a patient in congestive heart failure without significant changes in heart rate or blood pressure. These changes lead to a reduction in the left ventricular filling pressure, the pulmonary and atrial pressures, and the systemic and pulmonary peripheral resistance.

***"Bipyridines represent drugs that attempt to avoid the complications associated with digitalis and provide positive inotropic effect while minimizing the increase in heart rate and, thus, $O_2$ demand of the myocardium."***

No significant effects have been noted on the PR, QRS, QTc, AH, or HV intervals on ECG. The atrial effective refractory period and the atrioventricular (AV) node functional refractory period may be significantly reduced. There is a tendency to increase the 1:1 maximal AV node conduction. While at normal doses, amrinone does not appear to have an increased arrhythmogenic potential, at high doses there have been arrhythmias noted.

Milrinone is presently in clinical trials, and no definitive regimen has been proposed. It is noteworthy that Edelson has noted a 23 to 38% increase in the cardiac index with oral dose levels of 7.5 to 15 mg of milrinone (single dose).[12]

### Side Effects

The most significant side effect of amrinone is thromobocytopenia (2.4% incidence), which has occurred more often with prolonged therapy or when total daily doses are greater than 24 mg/kg and tends to be reversible. In the GI system there may be nausea, vomiting, abdominal pain, or anorexia; relative incidences are 1.7%, 0.9%, 0.4% and 0.4%, respectively. Cardiovascular side effects consist of arrhythmias (3.0%) and hypotension. As is the case with thrombocytopenia, arrhythmias are associated with higher levels and longer dose regimens. Hepatotoxicity may occur in 0.2% with IV dosage but is much more evident with oral dose regimens. Hypersensitivity reactions have been reported in patients who have received oral amrinone for greater than 2 weeks. These may be expressed as pericarditis, pleuritis, ascites, myositis, vasculitis, hypoxemia, and jaundice. General reactions may present as fever (0.9%), chest pain (0.2%), or burning at the injection site (0.2%). There has been one report of death occurring with an accidental overdose, but no solid association has been made. An experimental lethal dose was found to be 102-130 mg/kg in mice.[13]

Carcinogenicity and mutagenicity evaluations have been mixed. Carcinogenicity tests with rats have been negative over a two year period of testing. Some mutagenic tests have been positive: i.e., mouse micronucleus test (at 7.5 to 10 times the maximum human dose) and the Chinese hamster ovary chromosome aberration assay. While the Ames salmonella assay, the mouse lymphoma study and the cultured human lymphocyte metaphase analysis were all negative.[14]

### Interactions

Amrinone has been used with a number of drugs without drug interactions being noted except with disopyramide. It has exaggerated the hypotensive effect often seen with disopyramide. No interactions have been noted with digitalis glycosides, lidocaine, quinidine, beta blockers, ethacrynic acid, furosemide, hydrochlorothiazide, warfarin, insulin, diazepam, or $K^+$ supplements. In fact, it has an additive inotropic effect with digoxin without increasing

digoxin's toxic effects. When used with drugs such as captopril, hydralazine, or nitrates, the inotropic-vasodilator effects of amrinone are added to the vasodilator effects of these drugs.

### Clinical Applications

Amrinone has been approved for short-term use in severe congestive heart failure. It is applicable in the physiologic setting of low cardiac output and increased left ventricular filling pressure (>18). There exist a number of clinical settings where amrinone may be used. Patients with poor left ventricular function after cardiopulmonary bypass or patients with borderline left ventricular function, who are undergoing non-cardiac surgery might benefit from short-term use. Amrinone may be useful in severe congestive heart failure that is resistant to conventional therapy or acute left ventricular failure. Other settings are during an acute myocardial infarction with cardiogenic shock, after dopamine or dobutamine has proven ineffective; or with septic shock, after standard methods fail. It should be noted that in all these settings, amrinone is considered as a drug of last choice, based on the relative short time it has been available and the possibility of significant side effects.[14]

Acute MI, aortic or pulmonary stenosis, or hypertrophic cardiomyopathy are relative contraindications. In acute myocardial infarction, there is an increased risk of arrhythmias. If amrinone must be used, the patient should be pretreated with digoxin to reduce this risk. The contraindication with pulmonary and aortic stenosis is the same as with any vasodilator. With hypertrophic cardiomyopathy, amrinone may aggravate the obstruction.

***"No adrenergic receptor effect or inhibition of the NaK ATPase pump was noted. Rather, the bipyridines work through the inhibition of phosphodiesterase activity in the myocardium."***

Milrinone is presently undergoing clinical trials. As noted earlier, it is about 20 to 30 times as potent as amrinone. It differs from amrinone in that the inotropic response is accompanied by a slight increase in heart rate. The risk of arrhythmias is much lower than with amrinone. Milrinone is available in an oral form in which the risk of hepatotoxicity and thrombocytopenia is greatly reduced. One unexplained phenomenon in long-term use of milrinone is the occasional downhill course due to worsening heart failure that limits patient survival despite hemodynamic benefits produced by the drug.[15]

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# Cumulative Index

# *Journal of the Medical Association of Georgia*

# Volume 76 — 1987

| Month | Pages |
|---|---|
| January | 1-80 |
| February | 81-152 |
| March | 153-222 |
| April | 223-294 |
| May | 297-358 |
| June | 359-478 |
| July | 479-534 |
| August | 535-594 |
| September | 595-662 |
| October | 663-730 |
| November | 731-794 |
| December | 795-866 |

## Author Index


| Author | Page |
|---|---|
| Barker, W. Daniel | 556 |
| Barnes, Senator Roy E. | 817 |
| Beegle, Philip H., Jr., M.D. | 328 |
| Birdsong, George, M.D. | 825 |
| Black, Glenn J. | 561 |
| Black, Paul W., M.D. | 328 |
| Bland, Pierre B., D.V.M. | 16 |
| Blaney, Robert L., Ph.D. | 28 |
| Bloch, Alan B., M.D. | 839 |
| Blum, Rachael, J.D. | 61, 181 |
| Bohler, C. Emory, M.D. | 512, 739 |
| Bostwick, John, M.D. | 336 |
| Bowen, P. A., M.D. | 766 |
| Boyd, Carl R., M.D. | 129 |
| Brabson, Max L. | 566 |
| Bryant, Milton F., M.D. | 111 |
| Camann, Mary Ann, R.N., M.N. | 629 |
| Charles, Sara C., M.D. | 171 |
| Chaudhary, Bashir A., M.D. | 133, 641 |
| Chaudhary, Tesneem K., M.D. | 133 |
| Chow, Wong-Ho, Ph.D. | 586, 788 |
| Clark, Jane E., M.N. | 346 |
| Clark, S. William, M.D. | 251 |
| Cohen, Richard W., M.D. | 97 |
| Coil, James H., III | 64 |
| Collins, Jan | 203 |
| Davis, P. Charlton, Jr., M.D. | 771 |
| Davis, Stephen, Ph.D. | 186 |
| Day, James O., M.D. | 777 |
| Dillon, Susan J. | 618 |
| Divinyi, Joyce | 689 |
| Drake, Charles E., M.D. | 279 |
| Duttenhaver, John, M.D. | 349 |
| Early, Ann, M.D. | 494 |
| Ermutlu, Ilhan M., M.D. | 527 |
| Facklam, Richard R., Ph.D. | 839 |
| Faria, Miguel A., Jr., M.D. | 775 |
| Feldman, Walter S., M.D., J.D. | 370 |
| Ferguson, Charles M., M.D. | 643 |
| Fokes, Ernest C., M.D. | 115 |
| Foltz, Ann T., R.N., D.N.S. | 284, 346 |
| Foster, Charles L., Jr. | 547 |
| Friedman, Brion D. | 691 |
| Galloway, Ronald R., M.D. | 70 |
| Gay, Evelyn Ward | 235, 241 |
| Gelbart, Arthur O., M.D. | 627 |
| Goodroe, Joane H., R.N. | 206 |
| Gordon, J. Nicholas, M.D. | 498 |
| Gray, Stephen W., Ph.D. | 813 |
| Greenberg, Raymond S., M.D., Ph.D. | 586, 788 |
| Greene, Richard | 138, 268, 578 |
| Griffith, William C., Jr. | 703 |
| Grindon, Alfred J., M.D. | 510 |
| Hamm, William G., M.D. | 515 |
| Hanzlick, Randy, M.D. | 494, 825 |
| Hartrampf, Carl R., M.D. | 328 |
| Harville, Gail, R.N. | 70 |
| Hatcher, Milford B., Jr. | 214 |
| Headley, William M., M.D. | 738 |
| Henderson, Kenneth C., M.D. | 255 |
| Henschen, Bruce, M.D. | 641 |
| Hodges, John M., M.D. | 695 |
| Hollis, Charles D., Jr., M.D. | 707 |
| Holmes, Sarah W., M.A. | 33 |
| House, M. A., R.N., M.S.N. | 766 |
| Huguley, Charles M., Jr., M.D. | 310 |
| Humphries, A. L., M.D. | 766 |
| Hurst, J. Willis, M.D. | 94 |
| Huttenbach, Dirk E., M.D. | 833 |
| Jankowski, Dallas P., J.D. | 845 |
| Jarret, Diane, M.D. | 825 |
| Jennings, Jane B., M.D. | 510 |
| Kane, Mark, M.D. | 260 |
| Kaufmann, James A., M.D. | 231, 368 |
| Kitchens, William R., M.D. | 70 |
| Klein, Luella, M.D. | 98 |
| Knopf, William K., M.D. | 206 |
| Knox, Robert E., Jr. | 142 |
| Lavoie, Michael R., M.A. | 117 |
| Lemke, Jimmy V., M.B.A. | 854 |
| Liff, Jonathan M., Ph.D. | 586, 788 |
| Lokey, Julian L., M.D. | 520 |
| Longe, R. Leon, Pharm.D. | 627 |
| Lowry, Jim | 576 |
| MacLeod, D. Scott, M.D. | 100 |
| Maliha, Georges M., M.D. | 111 |
| Mansberger, A. R., M.D. | 766 |
| Marsh, Sherry | 173 |
| Martin, Carolyn A., Ph.D. | 751 |
| McCarthy, Carol M., Ph.D., J.D. | 545 |
| McGee, Rose F., Ph.D. | 346 |
| McKie, Virgil S., M.D. | 771 |
| McKinley, Thomas W., M.P.H. | 839, 845 |
| Melcher, Richard W., M.D. | 627 |
| Menendez, Jack F., M.D. | 302, 366, 486, 508, 542, 606, 677, 743, 807 |
| Mooney, Al J., III, M.D. | 751 |
| Moore, William W., Jr., M.D. | 415 |
| Moses, Bill H., Jr., M.D. | 129 |
| Murphy, Douglas A., M.D. | 206 |
| Nahmias, Bridgette B., M.D. | 36 |
| O'Leary, Dennis S., M.D. | 503, 569 |
| Pafford, Ward, Ph.D. | 697 |
| Parker, Joseph A. | 566 |
| Peel, Jesse, M.D. | 33 |
| Phillips, Thomas W., M.D. | 69, 307 |
| Piccola, Gary E., Ph.D. | 28 |
| Powell, Ralph W., M.D. | 315 |
| Randolph, Erich R., M.D. | 852 |
| Rogers, Harrison L., Jr., M.D. | 620, 675 |
| Rowland, U.S. Rep. J. Roy, M.D. | 99 |
| Rumph, Frank, M.D. | 16 |
| Sabio, Hernan, M.D. | 771 |
| Sacks, Jeffrey J., M.D., M.P.H. | 125 |
| Sammons, James H., M.D. | 499 |
| Samuels, Barbara N., M.D., M.P.H. | 117 |
| Scaljon, Vickie Skandalakis, M.A. | 813 |
| Schatz, Gary, Ph.D. | 260 |
| Schroder, Jack Spalding, Jr. | 553 |
| Schuder, Gregg W. | 687 |
| Shirazi, Syed H., M.D. | 784 |
| Sikes, R. Keith, D.V.M./M.P.H. | 16, 125, 839, 845 |
| Skandalakis, John E., M.D., Ph.D. | 813 |
| Skelton, W. Douglas, M.D. | 40 |
| Smith, J. David | 839 |
| Sowell, Raymond H., Jr., M.D. | 751 |
| Speir, William A., M.D. | 133 |
| Strickler, Howard M., M.D. | 751 |
| Thomas, Luther M., Jr., M.D. | 573 |
| Thompson, David E. | 683 |
| Tippins, Barbara | 159 |
| Tolson, Mary Ann, R.N. | 129 |
| Underwood, Charles R., M.D. | 11, 14, 91, 161, 308, 365, 489, 540, 616, 674, 740 |
| Van Buren, James K., M.D. | 632 |
| Vandiver, Maureen | 162 |
| Vega, Roger A., M.D. | 212 |
| Waters, Don L. | 703 |
| Watson, John D., Jr., M.D. | 7, 89, 158, 229 |
| Webster, Robert M., M.D. | 802 |
| Whitwell, Joe, S.T.D. | 632 |
| Wilber, Joseph A., M.D. | 16 |
| Wilkes, L. L., M.D. | 638 |
| Williams, Byron R., Jr., M.D. | 784 |
| Wolff, Bernard P., M.D. | 515 |
| Zumbro, G. Lionel, M.D. | 70 |

# Subject Index


## —A—

**ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)**
AIDS in My Practice? (Nahmias) ..... 36
American Hospital Association Recommendations on AIDS Management (McCarthy) ..... 545
A Plague Amongst Us? (Underwood) .... 14
International Conference on AIDS in Children, Adolescents, and Heterosexual Adults ..... 56
Legal Issues Involving AIDS (Coil) ..... 64
Meeting the Mental Health Challenge of AIDS and Related Disorders (Holmes, Peel) ..... 33
The Georgia Task Force on AIDS (Skelton) 40
Surgeon General's Report on Acquired Immune Deficiency Syndrome ..... 48
AIDS: The Georgia Perspective (Bland, Wilber, Rumph, Sikes) ..... 16
Psychologic Issues Related to AIDS (Piccola, Blaney) ..... 28
The Implications of AIDS (Rogers) ..... 620

**ALCOHOL**
What Does Alcohol Consumption Cost Georgia? (Sacks, Sikes) ..... 125

**ALCOHOLISM**
A Comparison of Alcoholics and Cocaine Addicts One Year Following Inpatient Treatment (Strickler, Martin, Sowell, Mooney) ..... 751

**AMBULANCE SERVICES**
Ambulance Services in Georgia 1982-1985 (McKinley, Sikes, Jankowski) ..... 845

**AMERICAN CANCER SOCIETY, GEORGIA DIVISION**
The Georgia Division Enters Its 41st Year (Knox) ..... 142

**AMERICAN HEART ASSOCIATION, GEORGIA AFFILIATE**
Heart Month: A Look at Activities of the Georgia Affiliate (Macleod) ..... 100

**AMERICAN HOSPITAL ASSOCIATION**
American Hospital Association Recommendations on AIDS Management (McCarthy) ..... 545
Statement of the American Hospital Association Advisory Committee on Infections Within Hospitals ..... 546

**AMERICAN MEDICAL ASSOCIATION**
AMA Comes to the Peach State ..... 758
AMA to Meet in Atlanta (Rogers) ..... 675
The AMA Is Coming! (Bohler) ..... 739

**ANABOLIC STEROIDS**
Anabolic Steroids (Gordon) (MAG Med. of Sports Committee) ..... 498

**ARTISTS, JOURNAL COVERS**
About the Cover Artist, Constantin Chatov 300
About the Cover Artist: Dale Rayburn ... 601
About the Cover Artist: Ron Ransom .... 801

**ASPIRATION CYTOLOGY**
Aspiration Cytology in the Evaluation of Breast Masses (Ferguson) ..... 643

**ASSOCIATION NEWS** ... 74, 146, 217, 287, 303, 367, 487, 543, 608, 678, 744, 808

**AUTOLOGOUS BLOOD**
Frozen Autologous Blood — Not Generally Recommended (Grindon, Jennings) ..... 510

**AUXILIARY TO MAG**
"You Can Say No" (Marsh) ..... 173
A-MAG Annual Meeting ..... 196
Saying "No" to Sexual Involvement ..... 183
The Business of Legislation (Collins) ... 203
The Impaired Physician: The Role of the Spouse in Recovery (Talbott) ..... 190
Volunteerism Is Not Dead, But Alive, Well, and Working (Tippins) ..... 159
We Achieve — County Activities ..... 166

**AYERS, C. L.**
Remembering C. L. Ayers, M.D. ..... 681

## —B—

**BARTON, WILLIAM L., M.D.**
William L. Barton, M.D., A Pioneer in Otolaryngology (Faria) ..... 775

**BLOOD TRANSFUSIONS**
Frozen Autologous Blood — Not Generally Recommended (Grindon, Jennings) ..... 510

**BONE MARROW TRANSPLANTATION**
Bone Marrow Transplantation (Vega) ... 212

**BREAST CANCER**
Aspiration Cytology in the Evaluation of Breast Masses (Ferguson) ..... 643
Breast Cancer Treatment — Not As Simple Now (Phillips) ..... 307
John Brown Talks of Breast Cancer (Underwood) ..... 308
Mammography in Atlanta (Chow, Liff, Greenberg) ..... 788
Psychosocial Aspects of Breast Cancer (Clark, McGee, Foltz) ..... 346
Rehabilitation After Mastectomy (Bostwick) ..... 336
Screening for Breast Cancer (Huguley) .. 310
The Role of Radiation Therapy in the Treatment of Breast Cancer (Duttenhaver) ..... 349
The Surgical Management of Breast Cancer (Powell) ..... 315
Breast Reconstruction Following Mastectomy (Hartrampf, Black, Beegle) ..... 328
Locally Advanced Carcinoma of the Breast (Randolph) ..... 852

**BREAST RECONSTRUCTION**
Breast Reconstruction Following Mastectomy (Hartrampf, Black, Beegle) ..... 328

**BUSINESS ASPECTS OF MEDICAL PRACTICE**
The Practical Matters of Practicing Medicine (Divinyi) ..... 689

## —C—

**CALENDAR** ..... 9, 86, 165, 234, 301, 378, 484, 544, 607, 673, 747, 812

**CANCER SECTION**
The Georgia Division Enters Its 41st Year (Knox) ..... 142
Aspiration Cytology in the Evaluation of Breast Masses (Ferguson) ..... 643
Bone Marrow Transplantation (Vega) ... 212
Incidence of Melanoma (Chow, Greenberg, Liff) ..... 586
Mammography in Atlanta (Chow, Liff, Greenberg) ..... 788
Neoadjuvant Chemotherapy of Cancer (Lokey) ..... 520
Unproven Methods of Treatment (Phillips) 69
Locally Advanced Carcinoma of the Breast (Randolph) ..... 852
Anticipatory Nausea and Vomiting (Foltz) 284

**CARDIOLOGY (See also, HEART Section)**
The Future of Cardiovascular Medicine (Hurst) ..... 94

**CARDIOVASCULAR RESEARCH**
Abstracts From Symposium on Cardiovascular Research: Part I ..... 522
Abstracts From Symposium on Cardiovascular Research: Part II ..... 582
Abstracts From Symposium on Cardiovascular Research: Part III ..... 648

**CAROTID ARTERY**
Fifteen-Year Review of Extracranial Carotid Artery Injury (Moses, Tolson, Boyd) ... 129

**CHEMOTHERAPY**
Anticipatory Nausea and Vomiting (Foltz) 284
Neoadjuvant Chemotherapy of Cancer (Lokey) ..... 520

**CHRISTMAS**
Christmas Story (Underwood) ..... 803

**COCAINE**
A Comparison of Alcoholics and Cocaine Addicts One Year Following Inpatient Treatment (Strickler, Martin, Sowell, Mooney) ..... 751

**COINCIDENCES**
A Coicedence (Webster) ..... 802

**COMMUNITY INVOLVEMENT**
Physicians — Part of the Community, Too (Scaljon, Skandalakis, Gray) ..... 813

**CONGENITAL HYPOPLASIA**
Congenital Hypoplasia of the Left Anterior Descending Coronary Artery Simulating Myocardial Ischemia (Shirazi, Williams) 784

**CONTINUING MEDICAL EDUCATION (See also, CALENDARS)**
Foreign Travel and CME Credits: What Shoud Be Expected of Them? (Gay) ..... 235
Georgia Doctors Visit the U.S.S.R. (Gay) . 241
MAG Scientific Assembly November 1987 653

**COUNSELING**
Meeting the Mental Health Challenge of AIDS and Related Disorders (Holmes, Peel) . 33
Psychologic Issues Related to AIDS (Piccola, Blaney) ..... 28
Geriatric Psychiatry — Options and Opportunities (Camann) ..... 629
Physician and Counselor: Teamwork in Geriatric Care (Van Buren, Whitwell) .. 632

## —D—

**DERMATOLOGY**
Idiopathic Thrombocytopenic Purpura in Childhood: A Current Perspective (Sabio, McKie, Davis) ..... 771

**DIAGNOSIS RELATED GROUPS (DRGS)**
New DRG Proposal Expanded to Physicians? (Rowland) ..... 99

**DRUGS**
A Note to Pill Purchasers (Letter) ..... 371
Generic Drugs — Caveat Emptor? (Feldman) ..... 370
Physician, Write, "Brand Necessary" (Kaufmann) ..... 368

## —E—

**EDITOR'S CORNER**
Reform What — Reform Who? (Underwood) ..... 91
Wonderland — The Way It Was (Underwood) ..... 540
A Board — For What Purpose?? (Underwood) ..... 161
Ah, Sweet Summer! (Underwood) ..... 489
I Am Thankful for ... (Underwood) .... 740
John Brown Talks of Breast Cancer (Underwood) ..... 308
On Being Real (Underwood) ..... 365
On Forming Up Into Teams (Underwood) 230
The Golden Years (Underwood) ..... 616
The Secure Insecurity of Wealth (Underwood) ..... 674
The Shadow of Several Men and Women (Underwood) ..... 11
Christmas Story (Underwood) ..... 803

**EDITORIALS**
"Ask Not What. . . ." (Cohen) ..... 97
AMA to Meet in Atlanta (Rogers) ..... 675
Breast Cancer Treatment — Not as Simple Now (Phillips) ..... 307
Comments of Infant Mortality (Klein) .... 98
Frozen Autologous Blood — Not Generally Recommended (Grindon, Jennings) ... 510
Georgia Doctors Help Medically Indigent (Menendez) ..... 508
Georgia's New Tort Reform Laws (Kaufmann) ..... 231
New DRG Proposal Expanded to Physicians? (Rowland) ..... 99
Other Houses, Other Speakers (Bohler) .. 512
Physician, Write, "Brand Necessary" (Kaufmann) ..... 368
The AMA Is Coming! (Bohler) ..... 739
The Future of Cardiovascular Medicine (Hurst) ..... 94

The Implications of AIDS (Rogers) ..... 620
A Plague Amongst Us? (Underwood) .... 14
Physicians — Part of the Community, Too (Scaljon, Skandalakis, Gray) ..... 813
Opportunity From Times of Change (Vandiver) ..... 162
The Stomach Bubble: A Quick Fix or Another Fad? (Headley) ..... 738
**EMERGENCY MEDICINE**
Ambulance Services in Georgia 1982-1985 (McKinley, Sikes, Jankowski) ..... 845

## —F—

**FINANCIAL PLANNING**
Common Techniques for Overpaying Estate Taxes (Griffith, Waters) ..... 703
Financial Planning: Are You Getting the Real Thing? (Schuder) ..... 687
Health Maintenance for Your Money (Thompson) ..... 683
The Medical Professional as an Individual Investor: Often Misunderstood and Forgotten (Friedman) ..... 691
The Secure Insecurity of Wealth (Underwood) ..... 674
**FIRE DEATHS**
Fire Deaths in Fulton County, 1983-85 (Early, Hanzlick) ..... 494
**FOOD AND DRUG ADMINISTRATION**
Generic Drugs — Caveat Emptor? (Feldman) ..... 370

## —G—

**GALACTORRHEA**
Metoclopramide-Induced Galactorrhea (Day) ..... 777
**GEORGIA HEALTH NETWORK**
Georgia Health Network: More Than an HMO (Clark) ..... 251
**GEORGIA HOSPITAL ASSOCIATION**
The Georgia Hospital Association (Brabson, Parker) ..... 566
**GERIATRICS**
Anna's Story (Dillon) ..... 618
Evaluating the Disabled Elderly for Placement in a Skilled Nursing Home (Gelbart, Longe, Melcher) ..... 627
Geriatric Psychiatry — Options and Opportunities (Camann) ..... 629
Physician and Counselor: Teamwork in Geriatric Care (Van Buren, Whitwell) .. 632
The Golden Years (Underwood) ..... 616
Wesley Woods Geriatric Hospital: The First Specialized Hospital of Its Kind in the Nation ..... 622
**GLOMERULONEPHRITIS**
Poststreptococcal Acute Glomerulonephritis in Early County 1982 (Bloch, Smith, Facklam, McKinley, Sikes) ..... 839

## —H—

**HEALTHY LIFESTYLES**
Healthy Lifestyles: Involving Patients in Preventive Health Care (Menendez) ..... 743
**HEART SECTION**
A Case of "Torsade De Pointes": An Unusual Ventricular Arrhythmia (Drake) ... 279
Abstracts From Symposium on Cardiovascular Research: Part I ..... 522
Abstracts From Symposium on Cardiovascular Research: Part II ..... 582
Abstracts from Symposium on Cardiovascular Research: Part III ..... 648
Cardiac Transplantation in Georgia (Zumbro, Harville, Galloway, Kitchens) .... 70
Congenital Hypoplasia of the Left Anterior Descending Coronary Artery Simulating Myocardial Ischemia (Shirazi, Williams) 784
Heart Transplantation in Georgia: The Emory Experience (Murphy, Knopf, Goodroe) . 206
New Inotropic Drugs: Amrinone and Milrinone (Lemke) ..... 854
**HEART TRANSPLANTATION**
Cardiac Transplantation in Georgia (Zumbro, Harville, Galloway, Kitchens) .... 70
Heart Transplantation in Georgia: The Embroy Experience (Murphy, Knopf, Goodroe) ..... 206
**HEPATITIS B**
Hepatitis B in Your Medical Practice: Risks and Recommendations (Schatz, Kane) . 260
**HISTORY OF MEDICINE**
The Medical Association of Georgia House of Delegates — 1913 (Davis) ..... 186
**HOMICIDE**
Demographics of Atlanta's Homicide Epicenter: 1984 (Hanzlick, Jarret, Birdsong) 825
**HOSPITAL NEWS** ..... 748
**HOSPITALS**
Wonderland — The Way It Was (Underwood) ..... 540
American Hospital Association Recommendations on AIDS Management (McCarthy) ..... 545
Hospital-Physician Relations: Are We Headed for a Divorce? (Schroder) .... 553
Managing the Workload in State Mental Hospitals (Ermutlu) ..... 527
Overview of a Hospital (Foster) ..... 547
PRO Georgia 1987 (Thomas) ..... 573
Reflections of Tomorrow or, the Night of the Catcus, by Doctor Charlie and Ray (Lowry) ..... 576
The Challenge of a New Financial Perspective — How it Affects the Hospital/Physician Relationship (Black) ..... 561
The Georgia Hospital Association (Brabson, Parker) ..... 566
The Health Care Business (Henderson) .. 255
The Year 2000: A Look Into the Future of Hospitals and Medical Staffs (Barker) . 556
Wesley Woods Geriatric Hospital the First Specialized Hospital of its Kind in the Nation ..... 622
A Concept in Search of Fulfillment — How and Why the Joint Commission on Accreditation of Hospitals Was Formed and What It Hopes to Accomplish (O'Leary) 569

## —I—

**IMPAIRED PHYSICIANS**
The Impaired Physician: The Role of the Spouse in Recovery (Talbott) ..... 190
**INDIGENT CARE**
Georgia Doctors Help Medically Indigent (Menendez) ..... 508
**INFANT MORTALITY**
Comments of Infant Mortality (Klein) .... 98
The Effects of Excluding <500 Gram Infants on Infant Mortality Rates in Georgia (Samuels, Lavoie) ..... 117
**INOTROPIC DRUGS**
New Inotropic Drugs: Amrinone and Milrinone (Lemke) ..... 854
**INVESTMENTS**
Financial Planning: Are You Getting the Real Thing? (Schuder) ..... 687
Health Maintenance for Your Money (Thompson) ..... 683
The Medical Professional as an Individual Investor: Often Misunderstood and Forgotten (Friedman) ..... 691

## —J—

**JOINT COMMISSION ON ACCREDITATION OF HOSPITALS**
A Concept in Search of Fulfillment — How and Why the Joint Commission on Accreditation of Hospitals Was Formed and What It Hopes to Accomplish (O'Leary) 569
The Joint Commission's Agenda for Change (O'Leary) ..... 503
***JOURNAL* COVERS (See, ARTISTS)**
***JOURNAL OF THE MAG***
A Board — For What Purpose?? (Underwood) ..... 161
The Shadow of Several Men and Women (Underwood) ..... 11

## —K—

## —L—

**LAW AND MEDICINE**
Hospital-Physician Relations: Are We Headed for a Divorce? (Schroder) .... 553
**LEADERSHIP CONFERENCE, MAG**
Highlights of MAG's 1987 Leadership Conference ..... 193
Organized Medicine's Challenges Today: "The Good, the Bad, and the Ugly" (Sammons) ..... 499
The Joint Commission's "Agenda for Change" (O'Leary) ..... 503
MAG Leadership Conference, 1988 ..... 818
**LEGAL SECTION**
Hospital Peer Review in a Hostile Environment (Greene) ..... 138
The PRO Wants You! (Greene) ..... 578
The Tax Reform Act of 1986: A Thumbnail Sketch for Physicians (Hatcher) ..... 214
Tort Reform in 1987: A Significant Improvement (Greene) ..... 268
Legal Issues Involving AIDS (Coil) ..... 64
**LEGISLATION**
The Business of Legislation (Collins) ... 203
**LEGISLATIVE ACTIVITIES, MAG**
"Ask Not What . . ." (Cohen) ..... 97
Legislative Remedies to the Liability Crisis (Hollis) ..... 707
The Legislative Seminar (Menendez) .... 677
PIP, the General Assembly, and You (Menedez) ..... 807
**LETTERS TO THE EDITOR** ... 160, 364, 485, 604, 742, 806

## —M—

**MAG HOUSE OF DELEGATES**
A View of the House (Menendez) ..... 366
Medical Association of Georgia House of Delegates — 1987 ..... 198
Other Houses, Other Speakers (Bohler) .. 512
The Medical Association of Georgia House of Delegates — 1913 (Davis) ..... 186
On Being Real (Underwood) ..... 365
**MAG MUTUAL INSURANCE COMPANY**
Changing the Professional Liability Environment Through Good Practice Policies (Blum) ..... 181
**MAG SCIENTIFIC ASSEMBLY** ..... 713
**MALPRACTICE**
Malpractice Suites: Their Effect on Doctors, Patients, and Families (Charles) ..... 171
You and Malpractice Stress: IV. The Office Staff's Perspective (Blum) ..... 61
You and Malpractice Stress: V. A Death in the Family (Fokes) ..... 115
**MAMMOGRAPHY**
Mammography in Atlanta (Chow, Liff, Greenberg) ..... 788
**MEDICAL POLITICS**
A Personal Perspective Regarding Medical Organizations (Moore) ..... 415
Learning in Washington (Menendez) .... 606
Organized Medicine's Challenges Today: "The Good, the Bad, and the Ugly" (Sammons) ..... 499
The Health Care Business (Henderson) .. 255
(Menendez) ..... 486
**MEDICAL PRACTICE**
AIDS in My Practice? (Nahmias) ..... 36
The Practical Matters of Practicing Medicine (Divinyi) ..... 689
**MEDICAL STAFFS**
Reflections of Tomorrow or, the Night of the Catcus, by Doctor Charlie and Ray (Lowry) ..... 576
The Challenge of a New Financial Perspective — How It Affects the Hospital/Physician Relationship (Black) ..... 561
The Year 2000: A Look Into the Future of Hospitals and Medical Staffs (Barker) . 556
**MELANOMA**
Incidence of Melanoma (Chow, Greenberg, Liff) ..... 586
**MENCKEN, H. L.**
The Christmas Story (Underwood) ..... 803

## —N—

**NEWS CAPSULES** ..... 602, 688, 736
**NOSOCOMIAL INFECTION**
Statement of the American Hospital Association Advisory Committee on Infections Within Hospitals ..... 546

## —O—

**OBESITY**
The Stomach Bubble: A Quick Fix or Another Fad? (Headley) . . . . . 738
**ORGAN DONATION**
Organ and Tissue Donation, 1987 (Bowen, House, Humphries, Mansberger) . . . . . 766
**ORTHOPEDICS**
Arthroscopic Synovectomy in the Rheumatoid Metacarpophalangeal Joint (Wilkes) . . . . . 638
**OTOLARYNGOLOGY**
William L. Barton, M.D., A Pioneer in Otolaryngology (Faria) . . . . . 775

## —P—

**PATIENT CARE**
Reach Out and Touch . . . . . 514
**PEDIATRICS**
Idiopathic Thrombocytopenic Purpura in Childhood: A Current Perspective (Sabio, McKie, Davis) . . . . . 771
The Effects of Excluding <500 Gram Infants on Infant Mortality Rates in Georgia (Samuels, Lavoie) . . . . . 117
Adolescent Urine Drug Screening: A Cobb County Medical Society Program (Huttenbach) . . . . . 833
**PEER REVIEW**
Hospital Peer Review in a Hostile Environment (Greene) . . . . . 138
The PRO Wants You! (Greene) . . . . . 578
PRO Georgia 1987 (Thomas) . . . . . 573
**PHYSICIAN'S RECOGNITION AWARD RECIPIENTS** . . . . . 218, 615, 672
**POLITICAL ACTION COMMITTEES**
The Money of Politic$ (Barnes) . . . . . 817
**POLITICAL INVOLVEMENT**
Life Is Not a Spectator Sport! (Watson) . . 158
**PRESIDENT'S PAGES**
A Closing Message (Watson) . . . . . 229
A View of the House (Menendez) . . . . . 366
AMA Annual Meeting (Menendez) . . . . . 542
Becoming Involved (Menendez) . . . . . 486
Circle the Wagons (Watson) . . . . . 7
Healthy Lifestyles: Involving Patients in Preventive Health Care (Menendez) . . . . . 743
It's Your Organization (Menendez) . . . . . 302
Learning in Washington (Menendez) . . . . 606
Life Is Not a Spectator Sport! (Watson) . . 158
Profession or Trade? (Watson) . . . . . 89
The Legislative Seminar (Menendez) . . . . 677
PIP, The General Assembly, and You (Menendez) . . . . . 807
**PROCEEDINGS OF 1987 MAG HOUSE OF DELEGATES**
First Session — House of Delegates . . . . 382
Official Proceedings of MAG's 133rd House of Delegates First General Session . . . . 372
Report of Reference Committee A . . . . . 417
Report of Reference Committee B . . . . . 428
Report of Reference Committee C . . . . . 443
Report of Reference Committee D . . . . . 454
Report of Reference Committee F . . . . . 461
Second Session — House of Delegates . . 412
Unreferred Reports . . . . . 388
**PROFESSIONAL LIABILITY**
Changing the Professional Liability Environment Through Good Practice Policies (Blum) . . . . . 181
Legislative Remedies to the Liability Crisis (Hollis) . . . . . 707
**PSYCHIATRY**
Geriatric Psychiatry — Options and Opportunities (Camann) . . . . . 629
Managing the Workload in State Mental Hospitals (Ermutlu) . . . . . 527
Meeting the Mental Health Challenge of AIDS and Related Disorders (Holmes, Peel) . 33
Psychologic Issues Related to AIDS (Piccola, Blaney) . . . . . 28
**PSYCHOLOGY**
Psychosocial Aspects of Breast Cancer (Clark, McGee, Foltz) . . . . . 346
Meeting the Mental Health Challenge of AIDS and Related Disorders (Holmes, Peel) . 33
Psychologic Issues Related to AIDS (Piccola, Blaney) . . . . . 28
**PUBLIC RELATIONS**
Healthy Lifestyles: Involving Patients in Preventive Health Care (Menendez) . . . . . 743
"You Can Say No" (Marsh) . . . . . 173
**PULMONARY MEDICINE**
Multiple Pulmonary Nodules With Pleuritic Chest Pain (Chaudhary, Henschen) . . . 641
Oppressive Dyspnea and Pulmonary Edema in an Obese Somnolent Man (Chaudhary, Chaudhary, Speir) . . . . . 133
**PURPURA, THROMBOCYTOPENIC**
Idiopathic Thrombocytopenic Purpura in Childhood: A Current Perspective (Sabio, McKie, Davis) . . . . . 771

## —Q—

**QUIET THOUGHTS**
Anna's Story (Dillon) . . . . . 618

## —R—

**RADIOLOGY**
The Role of Radiation Therapy in the Treatment of Breast Cancer (Duttenhaver) . . 349
**REHABILITATION**
Rehabilitation After Mastectomy (Bostwick) . . . . . 336
**RETIREMENT**
Retirement: Is It for You? (Hodges) . . . . . 695
The Way It Is (Pafford) . . . . . 697

## —S—

**SCIENTIFIC ASSEMBLY, MAG**
MAG Scientific Assembly November 1987 653
**SOCIAL SECURITY**
What About the Social Security Medical Consultant? (Wolff, Hamm) . . . . . 515
**SOUTHERN MEDICAL ASSOCIATION**
A Personal Perspective Regarding Medical Organizations (Moore) . . . . . 415
**STOMACH BUBBLE**
The Stomach Bubble: A Quick Fix or Another Fad? (Headley) . . . . . 738
**STRESS**
You and Malpractice Stress: IV. The Office Staff's Perspective (Blum) . . . . . 61
You and Malpractice Stress: V. A Death in the Family (Fokes) . . . . . 115
**SUMMER VACATION**
Ah, Sweet Summer! (Underwood) . . . . . 489
**SURGERY**
Arthroscopic Synovectomy in the Rheumatoid Metacarpophalangeal Joint (Wilkes) . . . . . 638
Fifteen-Year Review of Extracranial Carotid Artery Injury (Moses, Tolson, Boyd) . . . 129
Southeastern Surgical Congress — Tentative Program . . . . . 87
Surgical Treatment of Varicose Veins: A Downward Trend (Bryant, Maliha) . . . . 111
The Stomach Bubble: A Quick Fix or Another Fad? (Headley) . . . . . 738
The Surgical Management of Breast Cancer (Powell) . . . . . 315
Breast Reconstruction Following Mastectomy (Hartrampf, Black, Beegle) . . . . . 328

## —T—

**TAX REFORM**
The Tax Reform Act of 1986: A Thumbnail Sketch for Physicians (Hatcher) . . . . . 214
**TAXES, ESTATE**
Common Techniques for Overpaying Estate Taxes (Griffith, Waters) . . . . . 703
**TEENAGE SEX**
"You Can Say No" (Marsh) . . . . . 173
Saying "No" to Sexual Involvement . . . . . 183
**THANKSGIVING**
I Am Thankful For . . . (Underwood) . . . . 740
**THIRD PARTY PAYORS**
The Health Care Business (Henderson) . . 255
**TORT REFORM**
Reform What — Reform Who? (Underwood) . . . . . 91
Georgia's New Tort Reform Laws (Kaufmann) . . . . . 231
Tort Reform . . . . . 13
Tort Reform in 1987: A Significant Improvement (Greene) . . . . . 268
**TRAVEL**
Foreign Travel and CME Credits — What Should Be Expected of Them? (Gay) . . 235
Georgia Doctors Visit the U.S.S.R. (Gay) . 241

## —U—

**URINE DRUG SCREENING**
Adolescent Urine Drug Screening: A Cobb County Medical Society Program (Huttenbach) . . . . . 833

## —V—

**VARICOSE VEINS**
Surgical Treatment of Varicose Veins: A Downward Trend (Bryant, Maliha) . . . . 111
**VENTRICULAR ARRHYTHMIA**
A Case of "Torsade De Pointes" an Unusual Ventricular Arrhythmia (Drake) . . . . . 279

## —W—

**WESLEY WOODS GERIATRIC HOSPITAL**
Wesley Woods Geriatric Hospital the First Specialized Hospital of Its Kind in the Nation . . . . . 622
**WILLS**
Common Techniques for Overpaying Estate Taxes (Griffith, Waters) . . . . . 703

## —X—

**X-RAY CHALLENGE**
Multiple Pulmonary Nodules With Pleuritic Chest Pain (Chaudhary, Henschen) . . . 641
Oppressive Dysnea and Pulmonary Edema in an Obese Somnolent Man (Chaudhary, Chaudhary, Speir) . . . . . 133

## —Y—

## —Z—

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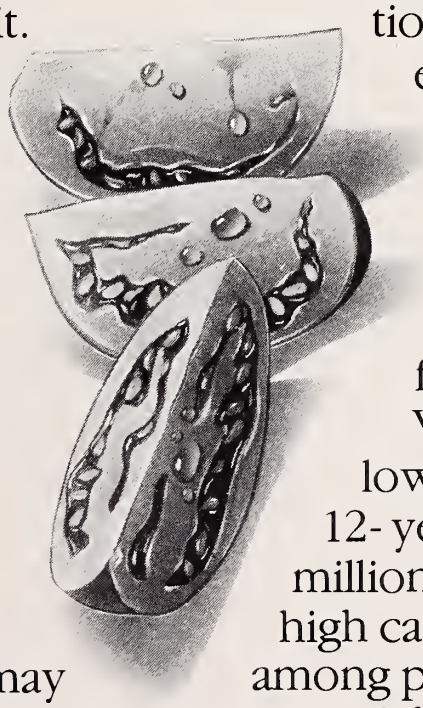

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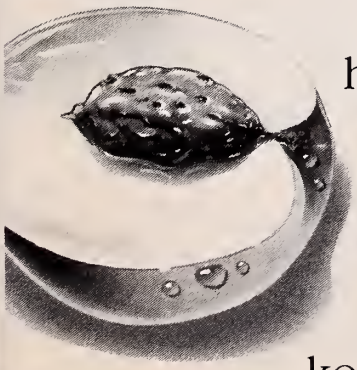

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# ADVERTISING INDEX


American Cancer Society ..... 806, 814, 863

American Heart Association ..... 806

American Liver Foundation ..... 837

American Lung Association ..... 844

Army Reserve ..... 800

Atlanta Magnetic Imaging ..... 832

Burroughs Wellcome ..... 814C-D, 815

Classified Ads ..... 862

CNA Insurance ..... 824

CPC Parkwood ..... 851

Family Practice Recertification ..... 816

HCA Palmyra Medical Centers ..... 798

Health Quip, Inc. ..... 797

International Computer Solutions ..... 838

Lilly, Eli & Company ..... 814B

MAG Mutual Insurance Company ..... 796

Medic Computer Systems ..... 805

M$ny Credit ..... 797

Roche Laboratories ..... 865, 866

U.S. Air Force ..... 816

Weight Watchers of Greater Atlanta ..... 797

Woodridge Hospital ..... 844


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